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ABSTRACT

Impressions of health educators in the specialty fields of community, patient, and school health are presented concerning the scope of their profession, commonalities and differences in their professional preparation, and recommendations for directions to follow in developing a systematic and coordinated competency assurance program. This information, gathered in a 1978 workshop, is presented according to the following outline: (1) introduction background information, workshop format, fundamentals of a credentialing concept; (2) health education, state of the art, parameters of the profession presentation, conclusions, and background statements; (3) commonalities and differences in the functions of health educators presentation, conclusion, and background statements; (4) commonalities and differences in the preparation of health educators presentation, conclusions, and background statements; (5) overviewers' impressions on general progress and direction of the workshop deliberations; (6) workshop recommendations consensus of the group in relation to preparation and practice of the total field, regardless of practice setting or specialty focus; and (7) participant list. An appendix presents five "directional" and one "boundary" question, the answers to which indicate the primary determinants of the content of health educator professional preparation. (MJB)

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Preparation & Practice of Community, Patient, And School Health Educators

PROCEEDINGS OF THE WORKSHOP ON COMMONALITIES AND DIFFERENCES

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Division of Associated Health Professions
Bureau of Health Manpower
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PREPARATION AND PRACTICE OF COMMUNITY, PATIENT AND SCHOOL HEALTH EDUCATORS

PROCEEDINGS OF THE WORKSHOP ON COMMONALITIES AND DIFFERENCES

February 15, 16, and 17, 1978

FORWARD

Clearly delineated roles and functions, defined competency requirements, and criterion based mechanisms for demonstration of proficiency constitute the foundation of a health profession's credentialing program. Its implementation necessitates agreement and acceptance by the total field of commonalities along these parameters. Health educators traditionally have worked in a variety of settings including community agencies, schools, and health care settings. This has given rise to emphasized affiliation with specialty focuses.

Since the mid 1960's, Health Education has been endeavoring to re-evaluate roles and functions of practitioners in each setting and concurrently the preparation and practice requirements for those prescribed areas. It was, however, expressed recognition within the field of a need to more systematically consider common grounds in preparation and practice, which stimulated the Division of Associated Health Professions to provide an initial forum in which commonalities and differences could be reviewed.

These proceedings reflect the views of the participants regarding the parameters of their profession, commonalities and differences in their preparation and practice and their recommendations for future directions. It also represents the profession's first step toward a systematic and coordinated competency assurance program.

We are pleased to have been able to assist in this effort.

Thomas D. Hatch

Thomas D. Hatch
Director
Division of Associated Health Professions
Bureau of Health Manpower
Health Resources Administration

April 1978

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CHAPTER I

INTRODUCTION

INTRODUCTION

In February, 1978, a workshop was held to bring together professional health educators from a variety of settings to discuss and analyze the commonalities and differences that exist in the preparation and practice of health educators. Specifically, the purpose of the workshop was to afford an opportunity for participants to exchange views concerning:

- The parameters and current State-of-the-Art of Community, School and Patient Health Education.
- The commonalities and differences in preparation and practice of health educators functioning in these various environmental settings.
- The potential for fashioning acceptable guidelines for professional preparation and practice that will include all of the health education settings.

Federal legislation attests to the expanding interest in health education. In 1974 Congress passed The National Health Planning and Resources Development Act, P.L. 93-641, which identified health education as one of the ten priorities to be considered in the formulation of health planning goals and resources development programs by federal, state, and areawide health planning agencies. Two years later, in The National Consumer Health Information and Health Promotion Act, P.L. 94-317, Congress stated more explicitly the role of the Federal government in fostering health education activities. This Act directed the Secretary of HEW to "formulate national goals and a strategy to achieve such goals, with respect to health information and health promotion, preventive health services and education in the appropriate use of health care." Moreover, it directed the Secretary to undertake activities that would:

- "Incorporate appropropriate health education components into our society..."
- "Increase the application and use of health knowledge..."
- "Establish systematic processes for the exploration, development, demonstration, and evaluation of innovative health promotion concepts"

Other legislation, past and pending, also reflects the increasingly important role that health education will play in the health care policies of this country.

Dr. Daniel Whiteside, Director of the Bureau of Health Manpower, (BHM) HRA, in underscoring the timeliness of the Workshop in his opening remarks, noted several implications for health education in recent health related legislative actions. Referring also to the skyrocketing costs of health care, he suggested it is not surprising that cost containment has become an underlying theme in most health legislation as well as Federal health programs. Currently, significant emphasis is being placed on disease prevention and health promotion and on motivation of individuals and groups regarding actions on behalf of their own health. These, he contended, are approaches to curbing the rate of increase in health care costs amenable to health education initiatives. In recounting the Bureau's long standing interest in this field, Dr. Whiteside stated that health education has become

not only a logical conclusion regarding quality of health, but a cost containment necessity requiring quality professional intervention. Mr. James Isbister, Vice President of The Orkand Corporation, stated in his opening remarks, that in a society that treasures freedom of choice, health education becomes the practical means to influence people toward beneficial healthy behavior.

The large number of professional organizations representing health educators at the workshop is indicative of the diversity in the field. Recently these organizations have actively begun to work together toward common goals. The Coalition of National Health Education Organizations, formed in 1972 in an effort to focus the interests and resources of eight national organizations upon health education issues is evidence of an effort to determine and implement common objectives. The conception of the National Center for Health Education to act as a national clearinghouse of health education research and program strategy is another example of the profession's eagerness to organize the communication channels within the profession.

In addition to defining the goals, functions and areas of preparation for health educators, this workshop represented an initial effort by professional health educators to investigate the possibility of establishing credentials for the profession. The Bureau of Health Manpower, Health Resources Administration, HEW, facilitated this effort by providing support for the workshop and lending its expertise in the credentialing process.

The conceptual framework of a credentialing program for a health profession, was described by Dr. Robert Conant, Chief of the Manpower Utilization Branch in the Division of Associated Health Professions at BHM. The entire text of Dr. Conant's presentation begins on page 5 of this chapter.

WORKSHOP FORMAT

Issue Presentations and Discussions

The three Issues reviewed during the Workshop were introduced in Plenary Sessions through formal presentations. The issues encompassed:

- Health Education - the State-of-the-Art - The Parameters of the Profession.
- The Commonalities and Differences in the Functions of Health Educators.
- The Commonalities and Differences in the Preparation of Health Educators.

The presentations were statements describing each issue and were not intended to answer the questions surrounding these issues. Rather, they "set the stage" for the discussions which followed. Discussion periods following the Issue Presentations resulted in conclusions regarding each issue. These conclusions and presentations are presented in Chapters II, III, and IV of the Proceedings.

Overviewers' Impressions

Dr. Lawrence Green and Dr. Elena Sliepcevich participated during the workshop as "Overviewers". Their role was to observe the general progress and direction of the discussion groups. During their presentations, they related their observations and impressions of the deliberations. Their presentations are presented in Chapter V of the Proceedings.

A CREDENTIALING CONCEPT

Robert M. Conant, Ph.D.,
Chief, Manpower Utilization Branch,
Division of Associated Health Professions
Bureau of Health Manpower,
Health Resources Administration, DHEW,

I am very pleased to be here this morning and share with you our perception of a credentialing concept. Equally as important, I am hopeful that you, as professional health educators, will, over the next few days of the workshop provide useful feedback to us.

PROGRAM OVERVIEW

I think it important to set the legislative stage very briefly for the credentialing program I will describe. Authority for the Departmental credentialing program administered by the Division of Associated Health Professions was addressed in the Health Training Improvement Act of 1970 (P.L. 91-519). The law contained two key elements which, subsequently, have interacted to provide a basic Departmental policy position for efforts directed toward assuring the competency of allied health practitioners. The first element was contained in Section 792(c) which provided special project support for "developing, demonstrating, or evaluating techniques for appropriate recognition (including equivalency and proficiency testing mechanisms) of previously acquired training or experience." The second element was Section 799(a) which required the Secretary to prepare and submit a Report[1] to the Congress identifying the major problems related to licensure, certification and other qualifications for practice or employment of health personnel. From this Report a series of Departmental actions and recommendations emanated. Important to our discussion today was a recommendation for the Department to encourage the development of meaningful equivalency and proficiency examinations for both entry into educational programs as well as occupational positions. Support for the recommendation was stated as follows:

> "When the validity of such examining can be established and proficiency more adequately assessed, reasons then exist to supplement the single formal education approach with a multi-experience route. The formal education option will undoubtedly continue to be desirable and, in some instances, preferred even though not always essential. For example, the availability of effective testing instruments will enable individuals who, due to their military training and experience, can demonstrate their competence to move directly into health service careers."

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[1]Report on Licensure and Related Health Personnel Credentialing, June 1971, U.S. Department of Health Education and Welfare, DHEW Publication No. (HSM) 72-11.

In 1972 the Division responded to the appropriate Departmental recommendations by publishing a document which established policy and rationale to implement the credentialing program.[2] I am going to defer discussion of some important objectives and principles of the program and focus on the methodology initially employed and our refinements over the ensuing years. Keep in mind, however, that a very basic objective was and is to develop evaluation instruments and related materials which address the performance requirements essential for competent practice. To achieve this objective we have pursued a criterion-referenced approach rather than the traditional norm-reference process.[3] I will digress for a moment to distinguish between the two approaches by relating them to examination development. Later I will expand upon criterion-referencing while discussing re-credentialing.

Most of you are quite familiar with norm-referenced examinations which primarily address recall of knowledge of facts obtainable from textbooks, formal lectures and the like. In the norm-referenced examination the performance of one individual is compared with that of other individuals taking the same examination and who form the normative group. What is observed in this type of examination is the traditional bell-shaped curve indicating a comparative distribution of individual scores. Most standardized examinations for assessing achievement or intellectual ability are classified as norm-referenced measures.

On the other hand, criterion-referenced examinations measure an individuals ability as it relates to some criterion, i.e., performance standard. The significance of an individual's score is not dependent on how he fares in terms of other examinees. The emphasis is on what the individual can do and not how well he competes with others. An example of this concept from a paper on criterion-referenced measurement published by Popham and Husek[4] is of the dog owner who wants to keep his dog in the backyard and, accordingly, gives the dog a fence-jumping test. The owner wants to find out how high the dog can jump so as to build a fence high enough to keep the dog in the yard. How his dog compares with other dogs is irrelevant.

With that very brief description of criterion-referencing, let me get back to the program process. The methodology includes three phases: role delineation, proficiency examination development and examination administration. Each of the first two phases contain multiple elements as follows:

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[2]Maryland Y. Pennell and David B. Hoover, Policies For The Development Of Credentialing Mechanisms For Health Personnel, Operation MEDIHC Newsletter, Vol. 2, No. 3, February, 1972.

[3]Robert M. Conant, Ph.D., Thomas D. Hatch, L.H.D., Policies For The Development Of Credentialing Mechanisms For Health Personnel - A Progress Report, The American Journal of Occupational Therapy, Vol, 28, No. 5, 288-291, May-June 1974.

[4]Popham, W. James and Husek, T.R., "Implications Of Criterion-Referenced Measurement", Journal of Educational Measurement, Volume 6, No. 1, Spring, 1969.

PHASE I - ROLE DELINEATION

A. Initial. The initial effort establishes, and with many health fields for the first time, the profession's perception of essential practice in terms of performance requirements. The primary basis for these requirements is existing functional data supplemented by expert input from practitioners, educators and service users (employers). Because of the "State-of-the-Art" of this process as well as that for the types of examination subsequently developed (criterion-referenced), these first efforts usually require further refinement.

B. Role Refinement and Verification. As indicated above, further refinement of the first effort is necessary to more clearly identify and focus the competencies as well as to verify their application to actual practice. Since identification of essential practice requirements form the basis for the development of relevant educational efforts, both basic and continued, as well as for competency based proficiency examination, it is essential that practitioner roles and related competencies be stated precisely and be acceptable to the field at a national level. Role refinement and verification is in no way duplicative of the initial role delineation for it serves a different purpose.

C. Educational Resource Document. Developed from the role delineation materials, this guide for curriculum design provides feedback to educational programs in order to emphasize the relevant elements of practitioner preparation essential to competent practice.

D. Self Assessment Instruments. Although developed to reflect the competency requirements identified through role delineation, and in a criterion-referenced mode, these instruments are not credentialing examinations per se. Rather, they provide a mechanism for practitioner self-evaluation. They also can be utilized, in a non-threatening sense, to profile a profession in order to develop and make available learning resource materials responsive to identified areas of deficiency.

E. Continuing Competency Resource Materials. These, in different forms, are developed to remediate areas of deficiency identified through self assessment profiles as well as to accomodate to changing practice requirements.

PHASE II-EXAMINATION DEVELOPMENT

A. Criterion referenced proficiency examinations are developed from Phase I outcomes of role delineation. As I have indicated, criterion-referenced examinations differ from the traditional norm-referenced credentialing examinations in that they establish a level (standard) of acceptable performance that all competent practitioners should attain rather than comparing individuals with resulting "acceptable" performance being determined by the average performance of the group.

This type of examination is new to the health field and, accordingly, the "State-of-the-Art" is continually evolving. This Division's credentialing program is at the leading edge of this endeavor and as such, is providing a national stimulus and direction in concept evolution.

B. Correlation Studies: To facilitate the acceptability of criterion-referenced examinations and procedures, it is essential to evaluate their

effectiveness in predicting performance of practitioners. To do this requires studies which will demonstrate the correlation between performance on the written examination to performance in the practice setting. By-products of this effort in many cases, are the development of an adjunct practical performance instrument and feedback which assists in sharpening the written examinations.

PHASE III - EXAMINATION ADMINISTRATION

The Division's position on examination administration has been to encourage the professions to accept them and administer them to serve the needs of all interested parties; the professional and governmental bodies, both State and Federal. Based on this concept the Division does not anticipate directly administering the examinations. On the other hand, proficiency examinations developed by the Bureau of Quality Assurance, HSA in collaboration with this Division, for Medicare reimbursement purposes, (Section 1123(a) of the Social Security Amendments of 1972) are being administered directly through the Federal Government. I would hasten to add, in our ever changing environment, this responsibility now resides in the newly formed Health Care Financing Administration and the legislative requirement for such examination administration expired at the end of 1977.

I would also add that although not involved in the direct administration of examinations, the Division has utilized this Phase to accomplish other goals that either directly or indirectly relate to administration of evaluation instruments. One such activity was in providing assistance in the development of the National Commission on Certification of Physician's Assistants. This Commission certifies to the competency of the assistant to the primary care physician through the administration of a nationally recognized proficiency examination. Currently there are 42 States that have legislative requirements for the primary care physician assistant. Of the 42 States, over 30 specifically recognize successful performance on the Commission's Examination as a requirement for practices. It is interesting to note that the Commission focuses on competency to practice independent of how such competencies were obtained. In this regard, eligibility to sit for the examination is not limited to graduates of formal educational programs but is also open to informally trained personnel who fulfill carefully prescribed experience requirements.

With this overview of the three program phases, I would like to identify the professions in which we have implemented these activities. In Phase I and II we have or are currently supporting projects in the fields of medical record administration, occupational therapy, respiratory therapy, diagnostic radiologic technology, environmental health, clinical laboratory technology and the assistant to the primary care physician. This latter effort is in addition to the National Commission activity mentioned previously. You will note that each of these fields has had an established credentialing process for some time. This is an important point. We do not automatically feel that all health professions need an elaborate credentialing mechanism for all members of the profession. Such mechanisms obviously impact on the cost of the services provided. It therefore becomes a responsibility of each profession to carefully consider the need for such a mechanism in terms of practice requirements and their impact on the patient/client.

In all facets of the program which I have described up to this point, there is a very fundamental and important point I wish to make. In all of these activities, our role is one of support to the professions. We are not going out and saying that you have to become involved and do things. On this basis, our involvement with a particular profession is entirely by its choice. We make knowledge of the program available; we try to make all health professions aware of it and then it is up to them to decide whether they want to pursue it or not. If a profession elects this course, we will do everything possible to help them implement a program.

We feel that there are a lot of important spin-offs from this program. Obviously we do not have the resources to support all professions but the inter-professional communications through various media have influenced a number of professions not being supported to utilize conceptual and methodological outcomes on their own. So whether they receive funds from us is immaterial; the direction is what is important.

I have mentioned briefly perhaps the "past" and the "present" and I think now I just might make a few comments on the "future".

In the past, initial certification generally has been the only point in the professional's career when evaluation has been conducted. It has become very clear over the last three to four years that further refinement to the process is necessary to ensure the competency of practitioners on a continuing basis. Indications for this have come from the professions, the public, and the legislators at both State and Federal government levels. The approach most verbalized as being responsive to this concern, is the periodic recredentialing of health practitioners. To effectively implement such a system there are certain basic principles or considerations that have to be recognized. I would like to share with you some perceptions of principles we feel to be important. These should not be interpreted as representing the only principles for consideration.

We have identified several as follows: The re-credentialing process should:

- Be criterion-referenced based
- Provide acceptable evidence of competency
- Identify the frequency for providing evidence of competency
- Deal with consideration of the credentialing implications of changing occupational role (generalist/specialist)
- Prescribe action when one does not provide evidence of competency
- Provide a national level of evidence

I will discuss each of them briefly.

Criterion-Referenced Base

Of all the basic principles essential to re-credentialing activities the concept that each, although important in its own right, be related back to a

performance criterion is critical. The criterion or performance standard identified, in terms of what an individual can or should be able to do, is the key to competency assurance and, therefore, the rationale for re-credentialing. Once developed and established, this criterion standard must undergo periodic reinspection to ensure that it is keeping abreast of a changing health care service system as it relates to the respective disciplines. Although one can only speculate as to a reasonable frequency for such reinspection, a hint to it may be provided by the realization of an inherent lag phase in translating perceived change into a dynamic system which includes: basic professional preparation, updating of evaluation instruments and continuing competency programs and, of course, the re-credentialing process itself. Obviously this lag phase will vary depending upon the extent of change in the criterion and the mode which is addressed. It may be greater for basic preparation than for continuing competency. In any event, for all that follows to make any sense, a commitment must be made by the profession, in concert with the educator and the provider, that the performance criterion established and implemented will be responsive to the continuing need for competency assurance as well as being responsive to changing health care needs.

Acceptable Evidence of Competency

The next principle of re-credentialing is that the process must collect evidence that the practitioner has the requisite competency, and that the evidence must be acceptable. It must be sound. To be acceptable it first must be criterion-referenced as I have noted. This means that not only must an examination, which may be used, be criterion-referenced; but so too must other evidences. For example, it means that standards of practice must be criterion-referenced. We tend to see standards of practice as meaning a criterion for good performance, and they should be.

Frequently, however, standards of practice do not offer sufficient detail for evaluating adequately the individual's competency. This does not mean they cannot be so structured.

The need for acceptable evidence means that approaches such as peer review must be so structured and operated as to produce quality evaluation. This is not simple.

It means that the supervisor performance appraisal, an approach suffering from the constraints of subjectivity, would be questionable and probably unacceptable evidence unless performed under situations which assure its best possible use, and only then when combining it with other methods of obtaining the needed evidence.

Requiring a specified number of continuing education hours, even if competency based, and even if part of a prescription education program, in itself does not provide acceptable evidence of practitioner competency.

I recognize that requiring specified hours of education often is no small achievement in itself, given the politics of professions and the feelings of members. I recognize that it does bring members to educational endeavors. So in no way am I saying that it does not make a contribution to the given professions. It does.

Let me emphasize that many of the efforts such as continuing education, self-assessment, prescription education, etc. are IMPORTANT CONTRIBUTIONS on the part of the professions leadership in helping the practitioner assure his expertise; BUT they should not be confused as constituting evidence of competency.

Various approaches to collection of evidence should be considered. The strengths and limitations of each should be studied and the potential part of each approach considered. For example, what is a chart audit? What can it offer in collection of evidence? What are its strengths and weaknesses? How most appropriately can it be used in collection of evidence about the competency of the practitioner? Should it be used in this endeavor?

Evidence which is acceptable will demonstrate the competency of the practitioner -- not just hint at it -- not just imply it. It well may take more than one method of collection of evidence to provide for a sound re-credentialing process which will assure client care by competent practitioners.

Frequency for Providing Evidence of Competency

How frequently evidence of competency, for re-credentialing purposes, should be provided is subject to many different answers, each with its own provision in terms of intervening activities and what may be considered as acceptable proof of competency? If re-credentialing is ultimately to be contingent upon re-examination (and I think it should be for reasons stated previously) then the interval may be more extended providing that the intervening activities are meaningful in addressing competency on a continuing basis. An example of such an interval, which has been implemented by the American Board of Family Practice, is six years. The Board has a mandatory examination for re-certification as a Diplomate. The National Commission on Certification of Physician's Assistants is also adopting a six year interval for re-examination with specified continuing education requirements to suffice between examination. Whatever span of time is chosen must be arrived at through development of a sound rationale.

Changing Occupational Role

The preceding basic principles or considerations have not noted any special circumstances. They have been essentially pitched in the context of a generalist practitioner. Although educational programs are geared toward preparing a broad based individual in the respective field, and indeed the majority of practitioners function in such an arena, a significant number do become specialized. Acknowledging this fact raises a number of questions which must be carefully considered in terms of a re-certification process. For example, when should evidence of competency be demonstrated for the truly specialty areas? Should the specialist be held responsible for possessing the competency required for the generalist area of responsibilities, or a part thereof? What is required of the individual shifting from generalist to specialist or the reverse? What credentialing and re-credentialing is to be required to assure the client of quality care and to provide assessment of the practitioner which is fair to the latter and does not impede his career mobility?

The given field must define well what is its generalist area of responsibilities. It must determine, if specialty areas do indeed exist in the field as distinct entities, not to be confused with limited variations from the generalist responsibility. If, in fact, speciality areas do exist, their delineation must be completed, and appropriate credentialing processes executed.

This is a complex matter which will require careful and responsible study by the professions, followed by sound actions.

Action for Non-Demonstration of Competency

Re-credentialing for the purpose of competency assurance becomes meaningful only, if a plan of action is developed which deals with those who do not provide evidence of competency. To allow unabatted practice would of course, defeat the intent of re-credentialing. On the other hand, to immediately, upon initial failure to demonstrate competency, make the practitioner no longer employable, is defeating the intent to the opposite extreme. Accordingly, steps to be taken must not compromise the patient but also should be equitable for the practitioner. In this context then, an action plan should prescribe how long and under what conditions the practitioner can continue to function before re-evaluation of competencies is conducted. Equally important is identification of areas of deficiency and a process to remediate them. The plan must also consider second and subsequent failures to demonstrate competency. At what point should a practitioner truly be determined as incompetent and barred from practice? An appeals procedure will have to be established; however, if each aspect of the plan is carefully and thoughtfully developed, need for such recourse should be minimized. It is evident from the foregoing that this basic principle may be the one most difficult to address.

A National Level of Evidence

Finally, I want to mention one more principle a profession must consider as it works out a re-credentialing process. That principle is -- that the evidence of ability which the system accepts as meeting the criteria is a system which provides for the evidence being accepted on a Nation-wide basis. If we think in terms of opportunities for practitioner mobility, both career and geographic, a system for re-credentialing developed to State or regional requirements would be most restrictive. Additionally, such variations would mandate the establishment of multiple re-credentialing systems within a single profession, a consideration of no small economic importance to the sponsoring professions. Thus the system should provide for acceptance of demonstrated competency on a nation-wide basis.

In closing, I wish you well. As a professional health educator you have significant opportunity to impact on our way of life. I am not sure that each of us will hear you, but that is an individual factor over which none of us has control. I will be here over the period of your effort and would be most pleased to discuss in greater depth any of the varied aspects of the "credentialing concept" that I have so briefly addressed.

CHAPTER II

HEALTH EDUCATION, THE STATE-OF-THE-ART, PARAMETERS OF THE PROFESSION

HEALTH EDUCATION, THE STATE-OF-THE-ART, PARAMETERS OF THE PROFESSION

Helen P. Cleary, D.Sc.
Associate Professor, Department of Family and Community Medicine
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Medical School

This is an historic occasion for health education. As we all know historic occasions do not just happen; they evolve over time as the result of vision, imagination and hard work. I can think of several happenings during the past few years which have contributed to making this workshop possible. No doubt each of you can add to my list which includes: the President's Committee in 1971; the Coalition of Health Education Organizations, which was the first effort to bring professional organizations for health educators together; and SOPHE's document on Professional Preparation and Practice in 1976, produced with the assistance of the Bureau of Health Education. It was the quality of this document which captured the interest of the staff of the Division of Associated Health Professions, the sponsor of this meeting. These events and others built the foundation which permits us to gather here today to consider the commonalities among health educators practicing in a variety of settings.

Health educators were given a very clear message by Dr. Whiteside and Mr. Isbister in their opening remarks this morning. Dr. Whiteside said, "Recommendations about the direction health education would take in the future were timely." Mr. Isbister said, "Health education must find its place effectively in the evolving structure, in legislation, regulations, payment for services. . ." The message as I read it is: HEALTH EDUCATORS GET YOUR ACT TOGETHER.

My assignment today is to identify the parameters of health education as practiced in schools, in community settings and in medical care institutions. In carrying out this assignment, I would like to do three things:

- Suggest three possible classifications for health educators.
- Identify the issues relevant to a consideration of the parameters.
- Suggest a framework which may be helpful in examining these issues.

THREE POSSIBLE CLASSIFICATIONS FOR HEALTH EDUCATORS

There are thousands of professionals who identify themselves as health educators. They could probably be classified in a number of ways. I would like to suggest three classifications which may be useful in our deliberations.

Function

The first is by function:

- Those who teach in schools and colleges, in medical care institutions or in community settings. This group includes school and college instructors of health courses, nurses teaching a class of patients (e.g., diabetics), and instructors in YMCAs and other community settings who teach classes in nutrition, exercise, etc.

- Those who plan, organize, coordinate and evaluate health education programs in schools and colleges, in medical care institutions and in community settings.

Health educators perform both functions to some degree, but the major responsibility for most health educators falls into one or the other of these broad categories.

Type of Institution

The second classification is by the type of institution in which the health educator works:

- The non-medical care institution, such as schools and community agencies, YMCAs, and adult education centers. Health education programs in these institutions focus on the development of healthful practices, understanding the body systems so as to maintain health, or learning skills and gaining knowledge to maintain health. Physical education programs, for example, whether in a school or a community setting, teach physical exercise and the value of regular physical exercise to health maintenance.

- The medical care institution, such as, hospitals, health centers, and public health agencies. Health education programs in these institutions are concerned with helping patients and families learn to cope with illness, and with prevention of disease, the negative side of the promotion of health.

It may be useful to elaborate on these two approaches. Let us call the first "health" education, and the second "disease" education. Health educators in medical care and public health settings do disease education. They either help patients and families learn to cope with an illness, or identify populations at risk and work with them to prevent the occurrence of illness. In the first case, we deal with individuals who are sick or perceive themselves as sick; in the second, we define a population as having the potential for the sick role, and deal with them around the need, as we define it, to adopt specific practices to prevent disease. The approach is essentially negative, (i.e., you do this because if you do not, thus and so will happen; and whatever will happen is definitely bad).

The health educator working in a school system, in an HSA, in a CAP agency, in community development projects, in extension services or other non-medical settings can deal with the promotion of health or can do health education in contrast to disease education. The target population is not defined as sick or potentially sick by the sponsoring organization. The approach is essentially positive, (i.e., diet, exercise, child care, etc., are issues of interest to people; because the quality of life usually can be enhanced if you consider these issues).

Professional Identity

The third classification is by professional identity. SOPHE's Committee on Professional Preparation and Practice identified three types of health educators: 1) those who teach health education in the schools, 2) those who

plan, coordinate and evaluate health education programs in schools and other settings, and 3) those with a professional identity other than health educator who do health education.[1]

Within these three types, further distinctions are necessary. Among teachers of health in the schools, some teach "health" subjects, such as mental health, human sexuality, first aid, and dental health. These courses are not necessarily part of a comprehensive health education curriculum. Some teach a comprehensive school health curriculum, such as, the Berkely plan. Some teach physical education; and some teach both health subjects and physical education.

Among those with a professional identity other than health educators who "do health education", some see health education as an integral part of their role but not as their primary function. This is true of nurses, dietitians, and other providers of medical care. On the other hand, many medical care institutions have a stoma nurse, a diabetic teaching nurse, or a pre-op teaching nurse whose primary function is teaching patients how to care for themselves. However, their professional identification is with nursing, not health education. The function of the nurse-educator is very much like that of a teacher of health in the schools.

The third type of health educator which SOPHE defined works in many settings, such as, hospitals: health planning agencies and industries. Theoretically, at least, the functions of the health educators in these settings are essentially similar, i.e., to plan, coordinate, organize and evaluate the health education effort in a given institution or community.

Given the goals of this workshop, I would like to suggest the distinction by professional identity that may be most useful. Although the distinction by the orientation of the work setting, i.e., health or disease, should not be ignored. That distinction, I believe, helps to explain some of the differences we observe in training programs for health educators.

I would also like to suggest that when we talk about the health educator at this workshop we are referring to a professional who identifies with health education as his or her primary profession; and with any professional who identifies health or disease education as his or her major responsibility and who works either full or part-time at the task of being a health educator. We are not concerned with nurses or dietitians or physical therapists or physicians for whom education is an integral part of their patient care role.

The central question we must address in the next two days is: What, if anything, do these classes of health educators have in common? Do they have a common knowledge base? Do they have skills in common? Or are these a group of essentially different professions with a common interest?

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[1]Society for Public Health Education, Inc., Task Force On Professional Preparation and Practice Of Health Education, "Guidelines For The Preparation And Practice of Professional Health Educators," Health Education Monographs, Vol. V, No. 1 (Spring 1977).

The most efficient way to address these questions, as I see it, is to identify the issues critical to a profession. An examination of these issues, will reveal what the various classes of health education have in common.

ISSUES RELEVANT TO CONSIDERATION OF PARAMETERS

Goals

In a paper prepared for the Bureau of Health Planning and Resources Development, HRA, titled, Planning for Public Education About Health, Sullivan raises the question as to what should be the "ultimate or central goal of health education"[2] He points out that there is a school of thought which believes optimum health is the goal by which health education should be measured; and another which sees behavior change as the goal regardless of the health consequences of this change; and still another which believes the goal of health education is to help people learn to identify options and make an informed decision about the selection of one of the options, i.e., after learning the consequences of their actions. This school considers attempts to motivate people to change practices as "manipulative, unethical and/or an invasion of privacy." Is there a goal under which we can subsume the specific goals of all classes of health educator?

Theory

Although we cannot address the issue of the theoretical base of the practice of health or disease education in these three days, we pose this as one of the most critical issues with which the profession of health education has to deal. In identifying theory relevant to practice, we begin to see wherein those who wear the label of health educator agree or differ.

Training or Preparation

Scott Simonds has provided us with information on the number of training programs, the number of health educators currently practicing, and the projected number needed by 1980. He does not claim his figures tell the whole story, but they do tell what is known about numbers in the profession. Scott's figures were compiled in 1975. Up to that time there were 224 training programs for health educators in the U.S.A. -- 49 of these were for community health education and 175 for teachers of health education in elementary and secondary schools.[3]

I have three questions about these programs: 1) What are they training health educators to do? (i.e., what is the knowledge base?) What are the skills and competencies for which students are trained? 2) How are they training them? What is the course content and practicum? 3) What is the

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[2]D. Sullivan, "Planning for Public Education About Health," prepared for Bureau of Health Planning and Resources Development, HRA, PHS, DHEW, (October 1976).

[3]Scott K. Simonds, "Health Education Manpower in the United States," Health Education Monographs, Vol. 4, No. 3, (Fall, 1976).

professional identity of students on graduation? How do they articulate the contribution of the profession of health education?

We need answers to these questions. We need to know what is being done in order to plan effectively for what needs to be done.

During the past 30 years and possibly prior to that, all the professional societies have prepared statements on the professional preparation of health educators. AAHPER has a 1967 document for graduate education and 1974 statement for bachelor level preparation. SOPHE published two documents in 1976, one, Guidelines for Professional Preparation and Practice at the Masters and Bachelors Level, and the second, Guidelines for Training Bachelor Level Health Educators. The School Health Association document for training school health educators was published in 1976.

As one peruses these documents, it is clear that the orientation of the school health and the AAHPER documents is different from that of SOPHE's document. Both AAHPER and School Health are in the school health tradition wherein health, not disease, is the focus. The SOPHE document has a public health/disease prevention orientation. Further program development and management, which is covered in some detail in the SOPHE document, is not mentioned in either of the other documents.

Two bachelor level training programs will illustrate this difference. A required course in one of the programs is Human Potential and Health Education, and in the other, Psycho Social Determinants of Change in Health Related Behavior. A comparison of the objectives and rationale for these courses points out that, although both deal with similar concepts, they do so within a different conceptual framework. The Human Potential Course emphasizes influencing life style or the quality of life as one grows and develops. To do so the student must understand what affects human behavior, as it develops. The Psycho-Social Determinants course seeks to have the student understand the "why" of human behavior viewed as having developed, and to learn how to intervene to influence behavior change. Although both these training programs are well integrated and have competent faculty, they have different goals, they are producing different products. One cannot attribute the difference to the administrative auspices of the programs. Both these programs are in Schools of Health, Physical Education and Recreation. As you know, training programs for health educators are found under a number of different administrative auspices, such as, schools of allied health sciences, schools of education, schools of public health, schools of communication, and schools of health, physical education, and recreation. Unlike the practice setting, the administrative auspices of a training program do not necessarily determine the orientation of the program, as my example illustrates. There is no guarantee that two schools of public health or two schools of allied health sciences, which offer a major in school or community health education, will have the same or even a similar curriculum in health education.

If we could be sure these two programs were illustrative of all training programs for health education, our task would be simple. But such is not the case.

The variability in content and quality of training programs for health educators, especially for community health educators, is a critical issue. A number of programs to train community health educators have sprung up in the

last 5-7 years. Some of these programs offer courses in health subjects and add a course in values clarification and behavior modification, and call it a training program for health educators. Even among the well developed training programs, there is great variability in content.

Programs for training teachers of health in schools are likely to have more in common than programs for community health educators because, in most states, teachers must be certified to teach.

Practice

The variability in training programs for health educators is, of course, reflected in practice. Recently, I asked the 50 states for information on requirements for teaching health education in the schools. Those of you who know the school health scene, know that the replies I received were as varied as the 50 states.

For the community health educator, as Beverly Ware said, "The variety of practice settings and functions is so great that the image of the professionally trained health educator is not clear."[4] This, together with the entry in the '60's of the health education aide and the bachelor level community health educator, has raised questions about levels of practice, a relatively new issue for health educators. Although professional preparation and practice documents have distinguished between bachelor's and master's functions, this distinction is useful only if it is accepted by the profession and by employers.

The confusion among health professionals and school personnel about the role of the health educator is due in part to fuzzy training programs which turn out students without a clear image of who they are and what a health educator does. It is also due to the variety of functions and job settings in which a health educator may apply the skills and competencies of the profession.

It would be helpful if we had hard data on the practice of school and community health educators.

Robert Bowman has pulled together data from several studies on the functions of health educators for the past thirty years. The health educators surveyed worked in official and voluntary agencies and were graduates of schools of public health.[5] However, we need to know, as well, what the graduates of schools of public health who are not working in official or voluntary agencies are doing; what the graduates of non-schools of public health are doing; and what the graduates of school health programs are doing.

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[4]Beverly G. Ware, "Directions for Health Education: New Spokes In The Wheel...Or A New Wheel?" Health Education Monographs, Vol. 4, No. 3 (Fall 1976).

[5]Robert A. Bowman, "Changes In The Activities, Functions, and Roles Of Public Health Educators," Health Education Monographs, Vol. 4, No. 3 (Fall 1976).

So that we may learn from what is being done, a survey of graduates of both bachelors and masters programs in community and school health education should be made to ascertain the positions they hold or have held in health education, the functions performed, problems encountered and issues in health education as they see them.

I would like to mention four additional issues which are not as critical in defining the parameters as the four just referred to; nonetheless, they are issues with which the professional societies must be concerned.

Research and Evaluation

There are a number of questions related to research and evaluation in health education including:

- What are the important questions for research?
- What is the priority of these questions?
- Who is identifying research issues in a systematic way?
- Who is attempting to attract substantial funds for health education research?
- We can learn from what we do, only if we know what we have done. To what extent are we promoting evaluation of health education programs, whether in school or community?

Continuing Education

The need for continuing education is basic to the survival of any profession. The teacher of health in the schools, like all other teachers, must participate in continuing education in order to get a promotion or a raise. While there may be problems with continuing education for school teachers, they are different than those for community health educators.

To date, there has not been pressure on community health educators to "keep up," nor have there been rewards for "keeping up." Only a few schools training community health educators have offered continuing education courses, and this is the source to which many look for continuing education. The professional health education journals offer excellent material for continuing education, but most of us are more likely to learn if we are involved in group discussion of the material in these journals, than if we attempt to digest them alone. Training institutions and professional organizations have a responsibility to provide continuing education for their graduates and members, and very few are doing very much about it.

Support Systems

Many health educators with little or no experience, and either a bachelors or master's degree in health education, take positions in agencies, schools or institutions where they are the only health educator, and sometimes, the first employed by that institution. They are alone, have no supervision, no role model and often work with others who do not fully understand what school or community health education is all about. These constraints place a burden on

the new professional with which many are not prepared to cope; in fact, it is unrealistic to expect them to do so. The fact that many leave the field or take positions with titles other than health educator is testimony to this. Both training institutions and professional societies have a responsibility to deal with this issue.

The "Untrained" Health Educator

In many professions, especially those with a heavy emphasis on process skills, there are a number of individuals carrying the professional title who do not have formal training. This is as true of administrators and planners as it is of health educators. When neither the goals of the profession nor the theoretical base, and so neither training nor practice, are clearly defined; it is very easy for anyone who wants to, to pick up the label and define the job in any way they wish. This is certainly the case with many in positions labeled health educator today.

How does the profession respond to this? At this time, there is a need for teachers of health and for health educators who can plan, coordinate and evaluate health education programs. Since we would all agree that education has an important role to play in promoting health and in preventing illness, then it is essential that those of us who are trained provide all the help we can to those who are not.

And at the same time, it is essential to define who we are, what we know and what we can do, so those who wish to have the label "health educator" can have the knowledge and skill base of the profession.

In defining the parameters of health education as practiced in schools, in the community and in medical care institutions, it seems to me, the issues of concern are: goals, theory, preparation, practice, research and evaluation, continuing education, support systems and the "untrained" health educator. The first four of these eight are most relevant to this workshop.

FRAMEWORK WHICH MAY BE HELPFUL IN EXAMINING THESE ISSUES

Finally, I would like to suggest a framework for consideration of these issues. The practices of health education can be conceptualized as a continuum from education for high-level wellness to education on death and dying. One may divide the continuum into education related to health and education related to disease; and within these two broad areas one may identify a number of different components.

The question we are to consider in the next two days is: What are the commonalities in knowledge and skills among professional health educators practicing along this continuum? The profession of psychology offers us an example. All psychologists begin with a common core. At the graduate level, one chooses to specialize in experimental, clinical, social or counseling psychology or a subdivision of one of these specialties. Further, within each branch of psychology, there are levels of training and practice.

Is this model useful to use? Do health educators have a common core of knowledge and skills regardless of the practice setting or type of practice? That is our question.

And now, with Isaiah and the late LBJ, "Come let us reason together."

CONCLUSIONS AND BACKGROUND STATEMENTS OF THE DISCUSSION GROUPS CONCERNING: HEALTH EDUCATION, THE STATE OF THE ART, PARAMETERS OF THE PROFESSION

Determining the goals and parameters of a profession is fundamental to arriving at an appropriate base for preparation and practice in the field. The first question posed to the discussion groups was, therefore, "What do you perceive as the goals of health education and the parameters of the field?"

After an initial generation of goal statements, participants realized that the statements they had come up with were quite diverse in terms of scope and content. They decided, therefore, to identify an overall or "umbrella" goal separately and to place more specific goal statements into a sub-goal or supporting goal category. These goals, as viewed by the workshop participants, in essence, set the parameters of the field. The goal statements listed below represent a synthesis of views expressed in the various discussion groups.

GOAL

The goal of health education is to maintain, promote, and improve individual and community health through educational processes.

Background: The discussants agreed that there are certain fundamental elements that should be incorporated into a general goal for the profession. The overall goal stated above sets forth the important link between health and education that is characteristic of the profession. It points out that the impact of health education is broader than disease prevention or therapeutic educational intervention. It covers educational activities relating to the maintenance, promotion and improvement of health. This goal, therefore, suggests the wide continuum between health and disease spanning both prevention and treatment. Moreover, it illustrates the dual concern for affecting health on both an individual and community level.

SUB-GOAL I

To foster or facilitate individual and community responsibility for the prevention of disease and management of optimum health status.

Background: One of the issues raised by the discussants was the question of responsibility for health. The discussants defined the difference between ultimate responsibility for disease prevention and health maintenance, and

the responsibility of the profession to facilitate individual and community acceptance of this ultimate responsibility. While they concurred that health educators help define behaviors which are positive or negative to health status, their prime responsibility is to facilitate health behavioral change processes, which have already begun within the society. In providing activities which motivate and stimulate people toward health related behavior, health educators assist providers and advance wellness maintenance. In addition to defining responsibility for disease prevention and health maintenance, this sub-goal also points out the continuum implied in the meaning of health - from disease to optimum health status.

SUB-GOAL II

To facilitate opportunities among individuals and communities to make "informed decisions" or "intelligent choices" regarding health and health behavior.

Background: The general consensus of the participants was that health education should provide a milieu in which change is possible. It should make the range of choices and the consequences of each choice apparent to the target population. The participants indicated that health education, as much as possible should involve facilitation not coercion or manipulation regarding health and health behavior.

SUB-GOAL III

To effectively stimulate community interest in health resulting in the development of consumerism, participation, conservation, and prevention.

Background: The participants viewed health for any individual as being, to a large extent, a result of community decision. They agreed that health education, therefore, must be specifically concerned with the role of the community in the maintenance, promotion and improvement of health. Reflecting the central importance of this issue, they concluded that community interest leads to, or depends on, informed decisions and increased acceptance of responsibility for health.

PARAMETERS OF HEALTH EDUCATION

Regarding the parameters of the field, the participants recognized that all of the health professions and occupations provide significant input to the health education process. Professional health educators (whether functioning in a patient, school or community setting) were, however, recognized as being

those individuals, whose professional identification and preparation is health education and whose major responsibilities and time commitments are directed toward facilitating intelligent decision-making about health status through educational processes. It was agreed that further delineation of the parameters of health education, including specific roles and functions, should be thoroughly explored.

CHAPTER III

COMMONALITIES AND DIFFERENCES IN THE FUNCTIONS OF HEALTH EDUCATORS

COMMONALITIES AND DIFFERENCES IN THE FUNCTIONS OF HEALTH EDUCATORS

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The topic for our next small group discussions centers around one word: function. That sounds very simple, doesn't it? For example, we could say that one does or one does not function. Clearly, this hotel did not last night.

I was reminded when asked to introduce this issue today that my task is to present the issue, not answer the questions surrounding and/or inherent within. We are to determine the commonalities and differences in functions of health educators in three major settings: school, community, and patient education.

The first thing I did was pull a dictionary off the shelf to check out the meaning of the word "function." The American College Dictionary defines it as "the kind of action or activity proper to a person, thing, or institution."

SOPHE, in its "Guidelines for the Preparation and Practice of Professional Health Educators" defines functions as "observable or measurable performances which are demonstrated in the application of knowledge and skill."

Accepting these definitions as not being mutually exclusive, in the next working session then we are to identify the observable or measurable performances in School, Community, and Patient Health Education which are demonstrated in the "proper" application of knowledge and skill. As if that were not enough, we must also determine whether those identified observable or measurable performances are common to all three settings (school, community, patient) or are unique to one setting.

Before going further, let me point out that the planning group is aware that you may have some questons about why these three settings were selected for differentiation. Of course, for many years health education has been dichotomized into School and Community Health Education. Recently, SOPHE indicated that the term Community Health Education no longer is fitting because of the variety of settings in which those who are labelled Community Health Educators work. Also, many may feel that Patient Health Education is, in reality, a part of this multi-setting Community Health Education.

Whatever your biases are, today we ask you to think in terms of the three work settings set down for this meeting. The School Health Educator clearly works the majority of the time in a school setting. The Community Health Educator can be functioning in a variety of settings within a community and the Patient Health Educator generally works with someone labelled a patient.

If, during the next few hours, we are going to have more than just some interesting rambling discussion, it is imperative that we work within some sort of framework.

In your goals discussion, you experienced the group nominal process to reach some sort of consensus in an organized fashion. We will be using a similar technique to get at commonalities and differences in the functions.

As you did in the last small group session, your chairman will instruct you individually to list three functions which you perceive to be common to all three settings (school, community, patient). Then, once again you will go through the round robin feed-back merely to record ideas. After they are all recorded for everyone to see, you will be handed a list of functions which have been gleaned from the various professional associations' preparation guidelines and position statements. Please keep in mind that this list is only a partial one and is meant only to assist you in your thinking at the discussion stage. There may be specific functions listed with which you do not agree -- and I am sure that there are many more which could be added.

Again, as you did before, you will ultimately rank these common functions in terms of how important you view them.

Now, you must be asking yourself how you can select only three functions common to all health educators when perhaps many exist. The list you will receive includes 138. It will be an impossible task if your focus is narrow and you think in terms of a series of very specific activities/functions. We, therefore, are asking you to conceptualize -- to report in terms of big ideas. Into what kind of a statement can you lump a whole series of very specific functions?

In order not to color your thinking regarding health education, I would like to present a simple example using another profession. There are many specialities in medicine, yet there certainly are common threads in how all physicians function. For instance, we might be able to say that practicing physicians, as a group, diagnose and/or treat illness and disease. Now I know you might find a few who are labelled physicians doing other things, but then one might argue that they are not truly practicing medicine. I am sure you can come up with many more examples.

If you fail to think in such a broad conceptual manner in your deliberations, the end results will be rather meaningless. In order to come up with a definitive list of very specific common functions, I am sure you will agree it would take several people many months of concentrated effort. Realistically we cannot do it in a two hour group discussion. You may want to make such a task one of your recommendations or resolutions at the end of the conference, but let us not try to do it in this short time period.

What I have described so far is 3/4 of your activity time during the next two hours. During the last 1/2 hour you will use the group nominal process to determine functions which are unique to one of the three settings. If you work in the capacity of one of the three -- or identify particularly with one of the three, use that one for selecting unique functions.

In this case you will silently generate two conceptual statements regarding functions which are unique to the School Health Educator, Community Health Educator, or Patient Health Educator.

Once again, you will go through all the steps with the exception of final ranking because you would end up with apples, oranges, and bananas if a ranking were attempted. These lists will be recorded and reported in the Proceedings.

It is important here also to think conceptually. Using the physician as an example again, we might say that a function unique to a radiologist is that he or she uses certain radiology equipment in diagnosis and treatment that is of such sophistication that only a radiologist is trained to utilize it.

As you personally think in terms of function, you are of course going to come up with several variables which will affect your decisions. You may find yourself puzzling over levels of functions (e.g., entry level vs. advanced on a continuum). Time devoted to a particular function may be a factor when determining commonalities among the three settings. Administrative skills may be found as a commonality, but they may be far more important in one setting than the other two. The level of expertise/competency required for certain functions may vary among settings. Target groups commonly worked with in one setting may be of entirely different age groups (e.g., school K-12 or 14) -- or at different levels of physical, social, or mental well-being. Physical settings for provision of services will vary and thus will impact how one functions. You will no doubt think of more such intervening variables.

We ask you to put all these thoughts into your mental computer and come up with big ideas - concepts - to identify those situations where there is indeed a general body of knowledge or set of skills which can be applied, once learned, in a variety of settings. As well as others which are unique to one setting.

We have a big task ahead, so at this point I will stop and we will try to answer questions you may have.

CONCLUSIONS AND BACKGROUND STATEMENTS OF THE DISCUSSION GROUPS CONCERNING: THE COMMONALITIES AND DIFFERENCES IN THE FUNCTIONS OF HEALTH EDUCATORS

In discussions on the commonalities and differences in the functions of health educators, the participants first identified broad general functions of the total profession. They then considered those functions unique to each specialty area. General functions of health educators were viewed as being common throughout all the settings of the profession, while the specific tasks subsumed under such headings constitute the differences. Moreover, these specific tasks were found to be relative to the setting, target population and motivation of the groups or individuals to whom the health education is directed.

Two significant definitions were addressed by the participants. First, the title of Patient Health Education appeared to be misleading when discussing the functions of a Patient Health Educator. Generally a "Patient Health Educator" does not deal directly with the patient, but rather with the medical staff of a health care facility who are in contact with the patient. The second definition related to differences between a health educator and a health instructor. Health Instructors are found within many different areas, and range from elementary school teachers prepared in other than health disciplines to YMCA physical fitness instructors. They are, however, not necessarily professionally trained health educators, since many have not been so prepared. The discussants agreed that this issue should not be ignored.

The discussants arrived at basic functions common to all health educators. Presented below is a discussion of these functions, as well as, a matrix describing the factors differentiating the functions within each area of health education.

FUNCTION I OF A HEALTH EDUCATOR

Assess health and educational needs and interests of the target population.

Background: This function encompasses two main assessment areas: the needs of the target group or individual and the political economic, physical, cultural, and social enviornment. The participants agreed that this is a fundamental function that must be performed before or in conjunction with the development of an educational strategy, as the educational strategy will differ greatly depending on the outcome of this function.

This function also links the health with the educational components of the profession. Not only must a health educator assess the health needs of a group or individual in a particular setting, he or she must also survey the educational needs of this target population.

FUNCTION II OF A HEALTH EDUCATOR

Design, implement, coordinate and evaluate health education activities to meet the goals of health education.

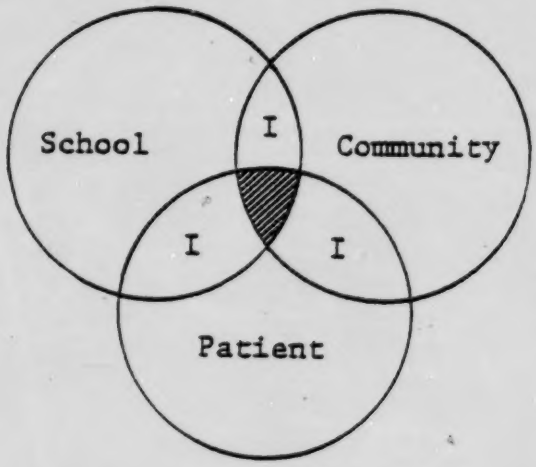
Background: This function addresses the "educational process" aspect of health education, beginning with the design of a program through its evaluation process. Each task inherent in this function (i.e., design, implement, coordinate, evaluate) is integrally related and must be performed in order to reach the objectives related to this function. However, the participants noted that the same individual may or may not perform all of these tasks. The point at which a given health educator becomes involved in the education process depends on the preparation of the health educator or the setting in which he or she operates. For example, the health educator with an advanced degree may design and coordinate the activity, while another health educator with a bachelor's degree or a non-health educator (e.g., nurse) may implement the activity. Most participants agreed that this function is a primary one for the health educator, as it involves development of an all-encompassing educational strategy that will meet the goals of health education.

FUNCTION III OF A HEALTH EDUCATOR

Coordinate multidisciplinary resources to enable an educational planning implementation process to exist.

Background: The participants concurred that a health educator functions as a central agent for facilitating and promoting health through education. Often, in order to discharge this responsibility, the health educator must integrate a wide variety of resources in order to facilitate the education of a given target population. The health educator must coordinate materials, personnel and facilities related to a particular health education program. Frequently, the health educator serves as member of a team of persons representing multiple disciplines whose time is extremely limited. In that situation, it becomes the responsibility of the health educator to coordinate and integrate the efforts of all team members so that time is used effectively and objectives are achieved as efficiently as possible.

In addition to multidisciplinary resources, it was recognized that interaction exists among Community, School and Patient Health Educators. They may interface by creating communication channels, sharing resources, and using media, as illustrated below.



I = Interface - creating communication channels, sharing resources, using media to set climate.

/// = Common Functions.

CHAPTER IV

COMMONALITIES AND DIFFERENCES IN THE PREPARATION OF HEALTH EDUCATORS

A FACTOR ANALYSIS OF THE PROFESSIONAL PREPARATION OF HEALTH EDUCATORS

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Since the November meeting that preceded this workshop, my early morning hours have been pervaded by a dream. Unfortunately, my dream has been a recurrent nightmare. I have elected to share it with you because -- well, it's hard to explain. Maybe it is because I think my dream was also meant for you. On the other hand, it may be that the dream is just too much for me to cope with alone. At any rate, I guarantee that it will get you worked up for the business at hand. So why don't you pretend that you are there with me during a typical dream sequence.

It's about 2:00 a.m., and I have been hauled into a spacious pyramid-shaped building and deposited before a door which reads:

DEPARTMENT OF UNIVERSAL WISDOM
PROFESSIONAL RESOURCES ADMINISTRATION
SERVICE FOR THE REFINEMENT OR ELIMINATION OF SLUDGY PROFESSIONS
BUREAU OF TRUTH IN PROFESSIONAL LABELING

The door opens and I am ushered to a single seat at the vertex of a triangular auditorium. I am face-to-face with the Bureau Chief, who appears to be backed up by approximately seventy-five members of the Bureau. The Chief speaks slowly and with an authority that one would be reticent to question, even if the Bureau were not a part of the Department of Universal Wisdom.

The Chief begins . . .

> In an atmosphere suitable for a major renaissance in health education, you have failed to develop as a profession. This failure can be traced directly to mental pygmies like yourself, who have failed to recognize the most elementary principles in professionalization. This Bureau is taking the time to acquaint you with these steps, after which, you have three years to develop or be eliminated as "professional sludge". The service

for the refinement or elimination of sludgy professions, of which the Bureau is a part, came into being when it was realized that certain groups, indeed entire countries, sometimes flourish better after "old ways of doing things" have been eliminated. This may well be true in the case of health education!

Now to some elementary facts. Professionalization begins with a group of people bound together by common purpose or purposes and operating within recognizable boundaries--boundaries known to those within and those outside the group. In your case, since we apparently can't be too simplistic, let me explain that it is these boundaries that enable you to call the plumber when the pipes clog and the physician when your child is sick. Without such boundaries you wouldn't know who to call for what service.

Giving me a sinister glance, the Chief lowers his voice to say:

Is there any problem in understanding this?

I turn my head quickly from side-to-side indicating that I understand. He goes on:

Having identified purposes and boundaries, the second step is to develop methods and approaches that are effective in accomplishing your stated purposes. A final step is to develop professional preparation schools to instruct those entering the profession in:

(1) The purposes and boundaries of the profession

(2) The proper use of valid methods and approaches

(3) The skills necessary to evaluate professional efforts and to advance knowledge within the boundaries of the profession

Having completed these steps, it is possible to credential the members of the developing profession. This latter process affords professional members certain rights to practice, denies such rights to those without credentials, and assures the client or consumer a certain quality of service and truth in labeling.

You are appearing before this Bureau because health education has denied the reality of these logical steps in professionalization. At present, you are preoccupied with methods and approaches for accomplishing a non-purpose within no established boundaries. This is what we label a sludgy profession. This is what you have three years to clean up! We note that many members of your group think of themselves as practical people who constantly lament attempts to reinvent the wheel or discuss philosophical matters. However, even practical-non-wheel-inventing groups must identify their purposes and boundaries.

Obviously, sludgy professions don't grow! To grow, you must define yourself and your boundaries in such a way that the consumer can make an intelligent decision as to how many truckloads of service might be needed. We suggest that, at the present time the consumer has no way of knowing what health education has to offer. You are a very ambiguous profession. Other professions, of course, have similar problems. But you have been called before the Bureau of Truth in Professional Labeling because you are attempting to exploit these ambiguities: that is, having failed to establish any boundaries, you are attempting to operate as if you had been given blanket credentials for all areas of professional practice. We will not tolerate this at the expense of the consumer. Either you come clean, as to what you are about, or you get the label "professional sludge."

Perhaps it would be useful if we were to provide some examples of not coming clean with the consumer or public.

Example One

One health educator, appearing before this Bureau, told us that health education has arrived at what he called a societal approach: an approach in which health educators work to introduce certain societal norms relating to health behavior. In turn, society applies sanctions to deviants with a "bottom line" of producing "desirable health behavior." We have serious questions about this approach. If a society feels that a specific health behavior is in its best interest, then that behavior should be mandated by law. In certain cases, this may be important, even essential. When, however, it is not "kept out front" and when the same end is

attempted in the name of health "educating," then there is a question of truth in professional labeling. You see, many consumers think of "education" as a way of liberating humans from the sanctions of society and facilitating free choice. Hence we cannot allow you to do something in the name of "educating" which is the exact opposite of what the consumer might expect.

We realize that there are many defintions of "educating," but we will not allow those differences to be exploited. We insist on "out front" usage. Hence, this "societal approach" must hereafter be labeled: "NONEDUCATIONAL, MAY BE DANGEROUS TO YOUR FREEDOM."

Example Two

Another health educator appeared before this Bureau and told us that health education consisted of identifying the determinants of health behavior and of discovering strategies whereby the determinants could be orchestrated to elicit specific behavior. He further stated that any "health educating" that could not accomplish this was unscientific, ineffective, and generally without value. We are uncertain as to whether you wish "behavior manipulation" to describe your professional boundaries. But whatever you decide, we must warn you that it does not constitute an "out front" definition of "educating". This approach must also be labeled, "NONEDUCATIONAL, MAY BE DANGEROUS TO YOUR FREEDOM." This is not to suggest that you should not participate in "behavior manipulation," or that it is without value, that kind of judgment does not fall within the purview of this Bureau. Our concern is that you don't label it "educating."

Example Three

Yet another of your group told us that the real value of health education was to assist people "who were willing to conform to good health behavior but could not do so on their own." In view of apparent informed consent, this approach does not involve the "freedom question", and until we can learn more about the approach we are withholding judgment as to whether it may be labeled "educating". At this stage, it appears that "behavior treatment" might be more "out front" but let's wait and see. A more pressing issue related to this approach is whether the "health educator" is really being trained to do this.

Example Four

Another of your profession really confused us by saying that "a real health educator" did not work face-to-face with those who were to be "health educated". Rather "the real health educator" was a "facilitator" of the face-to-face encounter. He couldn't give us a name for the person who conducted the face-to-face encounter, but we were assured that the "facilitator" was the "real" health educator. We suggested that it would be more "out front" to label the facilitator a "health administrator" or "health organizer" or something similar, but he was quite certain: health educator = facilitator of the health education encounter. It is hard for the Bureau to understand how your group came up with such unusual definitions of "educating". And get this, in one case we were told that health educators weren't really concerned with "health education"! Many others confirmed this! Do you really mean that some health educators are not concerned with health educating? This is really sludgy. We begin to think that you want "blanket credentials" to do everything except "health educate".

Example Five

An older health educator told us that at one time the boundaries of your group were defined by the term "biological integrity". He said that you were concerned with helping people to attain "full biological potential for physical and intellectual growth and development and for relating harmoniously and productively with one's fellow humans." He said that in recent times, however, you had gone beyond "biological integrity": on to "psychological integrity", and "social integrity", and "spiritual integrity"--in fact "total integrity or well-being". We further learned that it is now "unfashionable" to deal with "biological integrity", and that "biological systems approaches" were out-dated.

This is an important issue: Is biological integrity inside or outside your boundaries? We see it as being more important than ever! So you must either "take it in" and do something with it or put it "outside your boundaries" in order that other interested groups may "move in".

Example Six

An outspoken visitor told us that health education actually started with "biological integrity" as a "given": that is, it started with a person who exhibited an absence of illness, impairment, or disability, and attempted to help him attain high level wellness. He said that those dealing with "biologial integrity" were really "illness educators" not "health educators". High-level wellness is an attractive concept, but it doesn't help much with the question of boundaries! How will you prepare a high-level-wellness-educator?

Example Seven

Finally, we were told that the "real future" of health education was in something called "holistic health". There seemed to be no clear notion of what this was, but an attractive version suggested that it was an approach that attempted to consider the total individual in matters of health behavior. An example was very helpful in our understanding of this approach: the failure of young people to use effective contraception at first sexual intercourse was the example related to us. We were told that the problem did not stem from lack of knowledge regarding contraception, or unavailability of contraception, or purchase price; rather, we learned that the problem stems from a societal sanction which suggests that "premeditated contraception renders one morally questionable" whereas to "give in to passion" is only human. In this example, the holistic health approach legitimizes discussion of one's total life style--including a value system which suggests that self directed behavior may sometimes be less desirable than simply "giving in to one's immediate feelings." Others who discussed this approach, suggested that the aim was to assist the client with the wisdom required to make informed decisions about alternatives in health behavior. We inferred that those committed to this approach could study the alternatives in "behavior relating to health" and would attempt to initiate "the wisdom producing process" in others, who in turn, would be encouraged to make their own decisions. Evaluation would center around the question: Are decisions about "behavior relating to health" made in full view of contemporary wisdom? This appeared to be quite different from the question: Do the health educated exhibit desired behavior?

Example Eight

> Now, before you leave to consider these matters, we have one additional concern. The Bureau of Truth in Professional Labeling does not feel that you have "come clean" with those students that you have recruited into baccalaureate programs of community health. We suspect that you are misleading students about both the job market and the professional level at which they might expect to work. A number of bright students have elected to major in community health, expecting to tackle important health problems at a high professional level. After graduation, they find that the few jobs available are "grunt jobs". These, of course, are the kinds of jobs that many baccalaureate level people get today. But in your case, well, you are simply misleading people. Truth in professional labeling insists that you must be "out front" about the types and kinds of positions available to people at various entry levels. Is there really a market for baccalaureate-degree-community-health-educators?

The Chief turns to look over his shoulder. It appears to be his way of asking other members of the Bureau if anything has been forgotten. Then turning to me he says:

> At present you are not ready for professionalization. You have no defined boundaries. Rather, you "chase in one direction and then another." Unfortunately, no group can be given blanket credentials! Further, much of what you are now doing appears to be badly mislabeled. Skills for evaluation and advancing knowledge are limited. Health educators seem to be "professionally passive," waiting for opportunities rather than creating your future. Instead of "collective pride," health educators exhibit an attitude of "don't connect me with what others are doing."

By now it is hard for me to face the Chief. I want to tell him that he is wrong in his opinions of us, that we are sincere try-hard people. But I speak only to myself, vowing that I will be back in three years and health education will show them that we are not professonal sludge.

Then, as if he could read all my thoughts, the Chief says:

> You may go now. You have much to do. We will see you again in three years. Best of luck. We really don't enjoy labeling people "professional sludge".

As I am "collecting myself" to depart, a door in the back of the auditorium opens and a man rushes down the aisle to hand the Chief some notes. In turn, the Chief passes them to me saying:

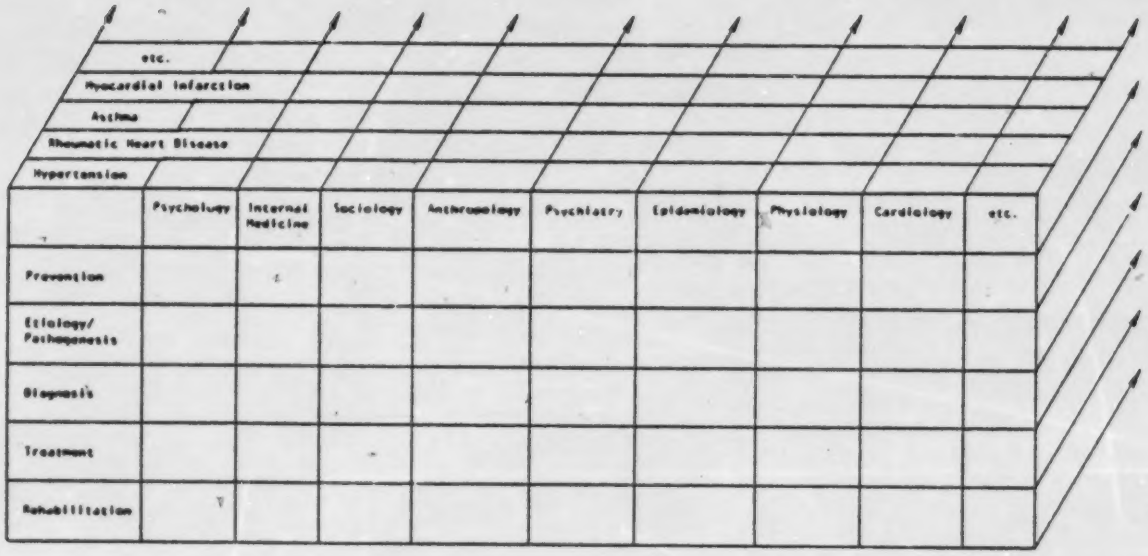
> Take these papers with you. Prior to your being called here, I requested that the Bureau complete an analysis of the commonalities and differences that appear to be a part of the professional preparation of health educators. For six months they collected information from various professional preparation schools and attempted a factor analysis of both "courses required" and "competencies stated." The results were without real meaning in both cases. However, the Bureau has prepared some worksheets that may enable you to identify your common elements. I am thankful that they arrived in time.

Having shared my dream, let me also give you a copy of the worksheets developed by the Bureau.

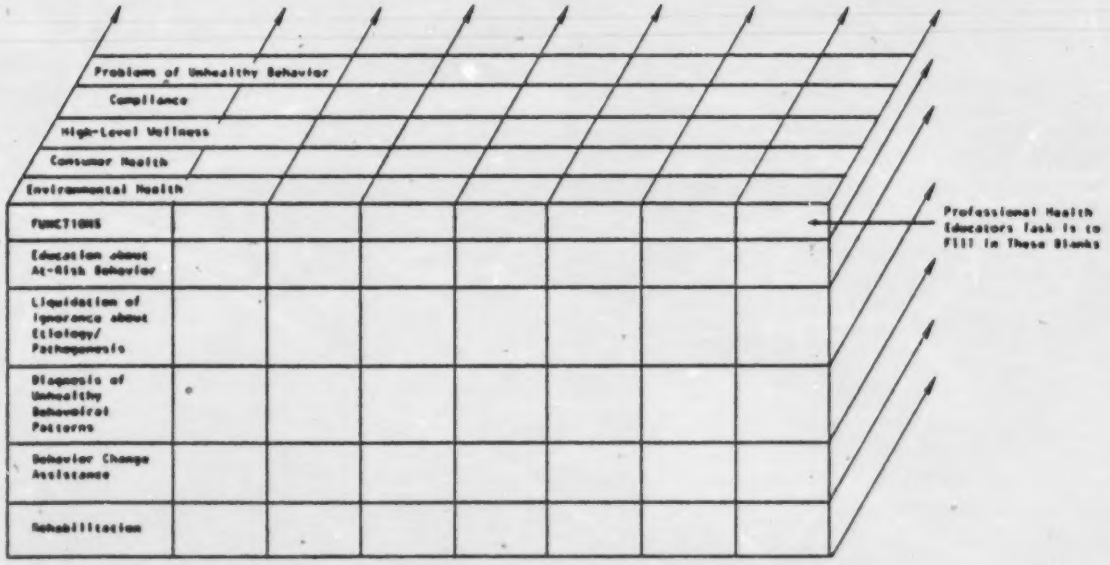
NOTE: The worksheets and results of the questions answered are found in Appendix A.

Dr. Burt prefaced his presentation with an illustration of a matrix presented at the Yale Conference on Behavioral Medicine, 1977. The matrix was used to relate the various functions of the profession to the basic and/or different areas of knowledge needed. Dr. Burt suggested that a matrix of this nature could be helpful to health educators when determining their functions and necessary areas of preparation. Matrix 1 presented below is the model used at the Yale Conference. Matrix 2 illustrates the type of health education model suggested by Dr. Burt.

MATRIX 1



MATRIX 2



CONCLUSIONS AND BACKGROUND STATEMENTS OF THE DISCUSSION GROUPS CONCERNING: THE COMMONALITIES AND DIFFERENCES IN THE PREPARATION OF HEALTH EDUCATORS

In discussion of the commonalities and differences in the preparation of health educators, the participants agreed that there are, in fact, common areas of preparation for health educators regardless of the projected practice settings. This base or "core curriculum" that could be applicable to all health educators encompasses components of the behavior and social sciences, biological sciences, educational theory and field experience. Presently, however, not all institutions that prepare health educators offer such a framework of study. Currently, preparation on curriculum emphasis varies, regardless of the setting in which the preparation occurs.

Though a degree of specialization begins at the baccalaureate level, major differences in the preparation of health educators surfaces at higher levels of preparation (i.e., master, doctoral levels) where specialization becomes more clearly defined. It was generally thought that it is at this point that a health educator focuses in depth on a specific area of practice (i.e., community, school, patient). However, the participants noted that there were also commonalities at this higher level of preparation, and that emphasis rather than content area was paramount. For example, every discipline of health education demands the common experience of a practicum, but the setting or target population of the practicum differs.

The preparation statements presented in this section have been developed from the conclusions reached by all four discussion groups.

PREPARATION STATEMENT I

A common core curriculum for all health educators needs to be established, followed by specialized curricula at the advanced levels for the various areas of health education.

Background

As with the discussions of the goals of health education, this statement surfaced to be the "umbrella" conclusion regarding the preparation of health educators. Early in the discussion, the participants wrestled with the issue of the entry level of preparation -- Is it at the baccalaureate level or graduate level? It was generally concluded that the baccalaureate should be considered the entry level to the field. It was noted that individuals with bachelor's degrees in health education are presently practicing in all the various settings. The participants further agreed that the necessary "common core" curriculum should be associated with the baccalaureate level with specialization occurring after the completion of the "common core" and at the advanced levels. They concurred that the focus of study at the entry level

should be such that the individual could gain a broad base and could function effectively in a variety of health education settings. There was a pervasive concern over the disjointed curriculums presently offered throughout the numerous institutions graduating "health educators".

The discussants agreed that this suggested framework of preparation for health educators at both the entry and advanced levels would not only better prepare these professionals, but would also facilitate placement of health educators according to their specific area and level of preparation.

PREPARATION STATEMENT II

At the entry level of preparation, a common core of skills and knowledge should be established and adopted that contain, at a minimum: behavioral and social sciences, biological sciences, educational theory and an effective field experience -- all of which integrate health education concepts.

Background

The participants agreed that these four major components constitute the framework of a "common core" curriculum. Sub-areas of preparation under each component were specified, not to solidify course prescription, but rather as a clarification of what the core contains.

- Behavioral and social sciences
  - Educational and social psychology
  - Cultural anthropology
  - Sociology
  - Humanities
  - Abnormal psychology
  - Economics
  - Human relations
  - Psycho-social understanding of the human system
- Biological Sciences/Health Sciences
  - Public health and health sciences
  - Epidemiology
  - Biostatistics
  - Biological understanding of the human system
  - Health problems
- Educational Theory
  - Education
  - Group and interpersonal theory and skills
  - Communication skills

- Current issues and trends in education
- Program/curriculum planning
- Research and application of statistical methods
- Foundations of all specialities of health education

- Field Study

  The participants concurred that a field experience should be included in the "common core" curriculum. However, there were varying views as to the length, type and settings of the practicum. Opinions on length ranged from one term to a full year (to be completed after four years of study). Although many of the participants felt the field experience at the baccalaureate level should involve several settings in order to give the student a broader range of experience, several others disagreed, stating this kind of practicum would perpetuate the "I can do anything and everything" health educator.

The participants felt that this "common core" curriculum with a focus on health education concepts in each area of study should be actively pursued and adopted by the profession and institutions of preparation. The final recommendations of the workshop reflect the urgency of this issue.

PREPARATION STATEMENT III

Specialized preparation should be established, primarily at the advanced levels, for specific health education settings and functions.

Background

It was concluded that commonalities appear less frequently as the professional becomes engaged in more circumscribed or specialized areas of practice within the field. Therefore, differences in the preparation become more evident as the area of study is more specifically defined. Three areas of health education (Community, School, and Patient) were discussed in terms of unique preparation.

- Community Health Education

  - Community organizational development
  - Group process
  - Public health laws
  - Problem analysis and program development
  - Survey research
  - Public information and communication
  - Referral process
  - Diagnosis of educational component of programs
  - Societal and political change
  - Field training in community health education setting

- School Health Education

  - Curriculum development
  - Coordination of a school health program
  - School health laws
  - Classroom teaching techniques
  - Testing and evaluation
  - Health content base
  - Student teaching
  - Education certification

- Patient Health Education

  - Medical terminology
  - Organizational development within a health care setting
  - Compliance with medical regimen
  - Medical sociology
  - Identification and selection of points for educational intervention
  - Handling of the sick or dying patient
  - Field study within a health care setting

These specific areas of training were not intended to be exhaustive, but rather were offered as efforts to distinguish preparation within Community, School, and Patient Health Education. The major resolutions of the workshop reflect the participants' eagerness to establish, in addition to a "common core" curriculum, definite areas of specialized preparation that will be adopted by the profession and institutions that prepare health educators.

Factors Differentiating the Functions Throughout Community, School, and Patient Health Education

	Community	School	Patient
Target Population	• At risk population as defined by particular health concern • Problem solving oriented, generally non-captive audience	• Young school age population (5-18 years, generally healthy) • Health promotion and disease prevention oriented • Captive audience	• Direct - Medical Care professionals within health care facility - medical content oriented • Indirect - Patients and/or families of patients
Setting	• Community in general	• Classroom/school system	• Health care facility
Motivation	• Community health related problems • General health promotion interest of community members	• School attendance required by law • Health and disease knowledge and health values	• Direct - Health care professionals need for educational process assistance, when instructing patients on health maintenance and disease management • Indirect - Presence disease or illness

CHAPTER V

OVERVIEWERS' IMPRESSIONS

IMPRESSIONS OF AN OVERVIEWER

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My task is to provide an overview, which means two things, given the placement in the program and the circumstances under which I was asked. For one, I take it to mean a half-time pep talk. We're in the locker room and you have to go back onto the field and I have to think of some way to encourage you to go forth. The other role or function of this series of presentations that Dr. Elena Sliepcevich and I are engaged in now is to try to provide you with some degree of objective, non-participant observer's evaluation of what has proceeded. Elena will look more objectively and specifically at some of the proceedings of the advancing work groups. The only thing that qualifies us as objective is that we tried not to participate in the dynamics of the groups. That was difficult. I failed repeatedly; I kept intruding myself. There was a time when I could understand why I would be asked to serve in this role. I was alleged to be objective, mainly because I had no opinions. Now I have developed some opinions, so I am probably unfit for this duty. I will restrain myself from divulging those opinions all at once, but my attitudes will be revealed as I present my impressions.

Evaluation of the Proceedings

The task of evaluation calls for a definition. I will come to the pep talk at the end, when you will need it most. I define evaluation simply as, "the comparison of an object of interest against a standard of acceptability." The object of interest is the proceedings of the meeting so far. The standards of acceptability are two: First, what have we been doing relative to what we might have been doing? Second, what have we been accomplishing relative to what we must accomplish, and relative to where we want to go?

1. What have we been doing relative to what we might have been doing? At the level of process evaluation, it struck me right away that the planning group owes the subgroups an apology for sticking them in a nominal group process for a problem-solution task. Nominal group processes were designed to identify problems not to solve them. I saw some groups struggling mightily on the first day trying to solve problems with nominal group process. It did seem to serve some useful purposes, however, so the planning group must have had some method to their madness.

It would have been more efficient had we gone about this in some other ways; it might have been more elegant had we done certain things; or more politically opportune had we done things a little differently. It might have been economic on behalf of our students and constituents had we gone a different path, but my conclusion is: we have been doing it right and I think we must keep doing it. Patience is required. Patience is what education requires, and the process we have been going through is an educational process.

It would have been more efficient, for example, had we started with the lists of competencies that have already been worked up by other groups. SOPHE, AHE and the American School Health Association all have developed documents that provide lists of competencies. We could have started there.

We could have picked those apart and we might have been more efficient in the process.

It might have been more elegant if we had started with philosophy. We might have identified some philosophical common ground and tried to work from there. I think we wisely avoided that trap. We would have had an existential crisis. We have in hand a good document on philosophy in the latest issue of Health Education, the AHE journal. So we had the philosophical background handed to us when we started and properly got down to work on substantive matters, rather than indulging ourselves in philosophical rhetoric.

It would have been more politically opportune, if we had looked around the country at what is going on — What are the trends? What are the catchwords? What are the fads that we can tie into? What could we do here that would be responsive to what seems to be in the press? That approach might have been politically opportune, but I think it would have been shortsighted. It would have been risky considering the transience of many of these kinds of trends and values. Health education in its conventional forms has not been spectacular, but it has been durable. The fact that we have resisted the temptation of some of the gimmicks of the past, and have outlasted some of the flashy substitutes for health education that have been offered by marketing, behaviorists and media experts should assure us that we have something worth codifying and possibly standardizing in what we are; rather than pursuing what others think we should be. We might as well have adopted the Bill of Rights or the Democratic Party platform as a starting point for this workshop, if political consistency and opportunity is what we need.

It would have been more economic on behalf of our students had we started with a job survey of what is available in the field for graduates of health education programs, and set about the identification of what students should be certified to do depending on where they are going to work. Again, I think that would have been shortsighted. I think any inclination to do that in the groups was wisely rebuffed as shortsightedness, and as an unwise way to go. Dr. Helen Cleary is absolutely right; we do need to know more about what is going on in the field. Not so much for the purpose of using it as a model for the future, as in correcting the past and trying to restructure our training programs, so that we avoid repeating the same errors in relation to the difficulties that our graduates are having in the field.

2. What would be the minimum outcome for this meeting, if we were to employ as our standard of acceptability, what we have been accomplishing relative to what we must accomplish? I interviewed all of our Bureau of Health Manpower hosts and sponsors. They assured me that the single minimum outcome that we should be striving for here is some sense of agreement that we have something in common worth standardizing. I am satisfied from the sessions that I attended, and from what has been presented by the groups, that we have successfully identified the commonalities worth standardizing. Let me put the emphasis on worth, not on standardizing. I think we have identified important commonalities. We were more facile in identifying commonalities than differences between the subspecialties of Community, School and Patient Health Education. I think these commonalities are ones worth doing something with. I have only one nagging question in whether they are worth standardizing, and I will underline standardizing, not worth. Do we really want a cookie cutter, standardized, sanitized, homogenized health educator? The groups did have more difficulty with the question of differences than with the

question of commonalities; but I did not take that to mean that they want all these people to look alike, to feel alike or to act alike, and certainly not to think alike.

THE RISKS AND BENEFITS OF CREDENTIALING HEALTH EDUCATORS

What is at stake in all of this? I have a list of seven things: quality assurance and quality control, professional birth control, training funds, jobs, reimbursement for health education services, making ourselves useful and acceptable to society, and protection of the public.

Quality Assurance and Quality Control

What we have in certification conceptually is a method of assuring that anyone who goes out to practice health education and represents himself or herself as a certified health educator, has met some minimum standard of acceptability with regard to what they know and to some extent what they can do. The question we have to ask in relation to this aspect of credentialing is whether we are premature in thinking that what we can test for assures quality in practice. I will develop this point a couple of times among the remaining remarks, because it is one of the most difficult to deal with. The question essentially is whether the things that we can test for in any kind of certification procedure assures us that once they know it and have the skill to do it, they will in fact do it in practice. All I can prove is that certification will not, by any means, be sufficient to assure quality or to provide an all-purpose quality control mechanism. It will contribute to quality assurance; but we are still going to have to go out and look at the programs, look at what practitioners do in the field, in the classroom or in clinical practice. We are going to have to assure that a continuing education mechanism is built into this, that there is peer review at some point in practice, and that programs and professional performance get evaluated periodically in terms of their impact and outcomes.

Professional Birth Control

One of the criticisms of certification is that professional societies have used it as a means of restricting entry into the field and; thereby, creating an economic monopoly. The American Medical Association and the Nursing Association have been criticized for doing this in their respective professions. We want to be sure that we are careful about what happens in a certification process relative to a licensing procedure, because the latter takes on the force of law. What happens with regard to the qualifications of people allowed to sit for the certifying examination; and what happens with respect to the stamp of approval, Good Housekeeping Seal, or whatever it is we put on people who pass these exams? We might do well to consider the social work model for certification as more appropriate, than the medical and nursing model. In social work, one gains an additional credential by being certified; but it is not, for most purposes, a passport that keeps anyone who does not have it out of practice.

Training Programs

This one is close to my heart. We had the bad news from our legislators a year ago, that health education had been written out of the amendments to the Health Manpower Act. Those who had a training grant from the Bureau of Health

Manpower were told that it would end at the end of this year, rather than going for the originally approved duration. In order for health education to be written back into the health manpower training act, I suspect it will require a clearer description of what it is that we are training. We are going to have to be better organized in representing to legislators what it is that health educators are able to do. There will be criticisms that we are being elitists and opportunists in expecting that a certification process, which usually ends up getting tied to the accreditation process, could be the grounds for funding only the accredited training programs. Only the institutions who can afford the accreditation procedure get accredited. Their students are then the only ones eligible for certifying exams, and so we perpetuate a closed system of restricted issue of people from the institutions that qualify for the process. On the other hand, when graduation from an accredited program becomes the only requirement for entry into a profession, a good student from an unaccredited institution cannot qualify for work in the field; whereas, a poor student from an accredited elite institution may qualify. If we could work it out so that certification does not necessarily have to be tied to accreditation, but both mechanisms of quality control are available, we would avoid that trap and that criticism. From what I have seen as basic commonality areas of competence, suggested by the groups, we are going to have to provide some assurance that a certified health educator has also been through a series of verified experiences in formal training or skill development. This can not be tested in certification examinations.

Jobs

People are being hired all over the country as health educators without training in health education. There are jobs that advertise for health educators and they are filled by people who have no particular training in the area either because they are more accessible or cheaper or somehow they sell themselves more effectively to employers of health education applicants. The questions, whether certification will make health educators more likely to get those jobs, hinge not so much on the quality of certification itself; but on how effectively we as the professional organizations can sell the employers on the quality of the certification process. Unless these employers believe that the certification exams assure them of a level of quality in the person they are going to employ, they will be happy to buy somebody less expensive and less qualified.

Reimbursement for Health Education Services

Medicare, Medicaid, Blue Cross and other third party payors all are looking for ways to assure that if they do support health education services, they are assured of some kind of consistency in the service that they have funded. Consistency is what they care about, as much as quality. They have to know at least when they pay a dollar for a health education service, that they are getting the same service for their dollar from one institution to another. We would be concerned about quality. As soon as National Health Insurance or Medicare or Medicaid amendments build health education reimbursement into their provisions, and they probably will, we can expect that there will suddenly be another burst of health education activity all over the country. That will result in more and more people without qualfications getting into the act of health education as we have been defining it here. More and more people doing health education, getting money

for it, building up empires, and so forth. All of that could very well lead to another dilution of health education in any sense of quality.

Making Ourselves Useful and Acceptable to Society

Consider, if you will, the fields that are not credentialed. Artists are not; architects are. What would we do with certified artists? We have to certify architects because architects perform a function for society that affects us all. If an architect cannot draw the plan for a safe building, then we are in trouble. Businessmen are not certified, but we do have certified public accountants. Again, there is an entrepreneurial, as opposed to, functional capacity for these two occupations that causes society to want to certify one and not to certify the other. Most salesmen are not certified, but insurance underwriters are. Again, society has to be protected from certain kinds of professionals. Therefore, we developed certification mechanisms primarily to meet society's needs for protection or assurance of an acceptable quality of service. Now, do we want health education to be entrepreneurial; do we want it to be artistic; or do we want it to be supported by society? If we want it to be entrepreneurial or artistic, we can hardly expect society to foot the bill. If we can show that health education does serve society, that it meets society's ends, then I think we are closer to understanding what it is we have to ensure that health education does. And that leads to questions of quality assurance again.

When you took the test for John Burt this morning, following his brilliant presentation, you were facing yourself with your own position on the fundamental issues that we are up against. Whether we liked it or not, (and I didn't) at the time I had to make the choice. Those choices are what we are facing. We have to decide whether we are certifying some kind of broad philosophical high-level wellness concept; or whether it is a set of skills in practice, through scientific knowledge, that can be related specifically to certain kinds of societal benefits. The key words that helped me make my decision, on whether I chose option one, two or three, were the words that had something to do with "the things that are left to philosophy, political science and religion". I have to admit, even though I believe in holistic health and I believe in high-level wellness, that I have very little that I can tell society about the evidence or that I can assure them will result from following a holistic health regimen. And even if I could show them what the benefits are, it would be in relation to my concept of high-level wellness, my concept of holistic health, and I am afraid that that is necessarily idiosyncratic and unstable. Given the State-of-the-Art for holistic health concepts and the tenuous, idiosyncratic indicators of positive health or high-level wellness; it is unlikely that we could expect to develop a certification examination that would test a health educator's competence in this type of health education.

Protection of the Public

I do not have a lot to say on this that I have not already said, except that I think the dictum that applies to medicine applies equally to health education: above all else do no harm. We can at least try to set that, as the fundamental criterion of what we are testing for. We want to be sure that we are testing for those areas of ignorance or incompetence that might cause somebody to: misinform the public, mislead the public, or apply techniques that are hazardous to the public's health.

RECOMMENDATIONS FOR CERTIFICATION PROCEDURES

First, we should not expect to test for attitudes in certification examinations. We have a highly developed technology for attitude testing that would never work for people who know what they are going to be tested on; and what attitude we are looking for. We can ask them a thousand questions that are highly reliable, but very invalid as a measure of their true attitude, if they know what you want to hear. So attitude will not be tested. Most of the high-level wellness, holistic health stuff is still in the attitudinal realm, and I suspect will not yield to testing. Practice skills can be tested to a certain extent — at least those that can be tested with pencil and paper such as: budgetary skills, statistical skills, interpretive skills, writing behavioral objectives. Those we can test for. We can assure that somebody has the skill to do their desk work. But when we want to know, if they can do them in the field, the clinic, or the classroom; or whether they know when to do them, or better yet, when not to do them, the test probably will not yield that determination. Therefore, I think we must expect that certification will have to be tied to and supplemented by other mechanisms of program evaluation, peer review, and continuing education. The second conclusion I draw, especially from the list of competencies that was presented this afternoon, is that there is a common core of knowledge that we can point to as being essential, and basic to health educators no matter what the setting or population we may be dealing with in practice. We could conceive, then, of a common core of basic knowledge and skill to test in a way that will apply to all of us. However, that probably would not be satisfactory to the sub-specialist. It would leave out a large area of specialty knowledge that some of you believe community health educators should have; some of you believe school health educators should have; and so forth. So we probably will have to have some kind of common core test with a specialty subtest, that people take, depending on the specialty for which they have prepared. That specialty subtest then could lead to questions related to the advanced areas of knowledge and skills. The third recommendation I derive concerns theory. Testing for theory will have to involve a mechanism that allows frequent revision, because we are in a fast moving field. Theory changes constantly in health education. The theoretical bases upon which are joined the scientific practice of health education change rapidly. It would be risky to have students preparing for that exam in relation to today's psychological theory and not testing subsequently on tomorrow's psychological theory. Teaching and learning theories are perhaps among the better grounded of those we draw upon, but administrative and management theories are changing very rapidly and they change as fast as institutions change. We are going to have to go into the practice setting as it is and see what people do, and how they function. We are going to have to have a mechanism that approves quality in every level of performance in addition to the knowledge and the skills of novice practitioners.

I would like to conclude with just two observations on John Burt's nightmare. One is that it reminded me of another nightmare, not that I admit to having, but which is common to people I know who have been awarded doctorate degrees. It is the nightmare about somebody finding your dissertation and recalculating the statistics, finding them all wrong. You wake up in a cold sweat, as they are coming to take your degree away. Right? That one leads to my point, that we could certify knowledge and skills by a test as rigorous as the dissertation process. However, unless we have some check and balance system on performance in practice, I think we may delude ourselves into thinking that we have assured quality.

My last observation on Dr. Burt's metaphor is that, if we are dealing for the moment with a sludgy profession, I hope that we can, at least temporarily, use Draino rather than Roto-Rooter. There is no final solution to the health educator problem. We can hope through certification to clean up our act, but pulling the chain on the whole act will, to mix the metaphor, flush a lot of babies with the bath water.

IMPRESSIONS OF AN OVERVIEWER

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As a preface to my observations of this Workshop, I want to express appreciation to the following:

to Dr. Whiteside, Mr. Hatch, Dr. Conant and Mr. Holland for their participation and support in making this workshop a reality;

to The Orkand Corporation--Mr. Isbister, Kathy McCasland and the other Orkand staff members for the efficient manner in which the workshop was organized;

to the Workshop Planning Committee for the many extra hours of time and effort devoted to the design and identification of issues, stimulating plenary speakers and representative participants;

to the Group Leaders, Recorders, and Reporters for the skillful manner in which they guided and summarized the group discussions;

and, finally, to Helen Cleary for her vision in pursuing the opportunity for all of us to come together for this historical event.

Let me elaborate on a couple of thoughts about the significance of this workshop.

Helen Cleary admonished us "To Get Our Act Together." As I thought about reports of various professional health conferences dating back to over 50 years ago, I am sure that those participants from health and education had the same goal of reaching common agreements as we have today. And when the curtain went down on the last act of each performance, there was cause for applause that something had been accomplished--or else we would not be here today.

Throughout the years, the show has gone on--the dialogue may be updated and the cast of characters changed; the settings may reflect contemporary times, but because the plot makes an appealing professional statement, the curtain rises again and again--and the show goes on attracting a larger, more diversified and supporting audience.

And so, I am optimistic that our "act" is coming together--and that the performers today understand and appreciate the roles and attendant responsibilities assigned to each of the cast much better.

A second thought was how encouraging it is that the Bureau of Health Manpower, Division of Associated Health Professions is interested in helping us to examine the feasibility of developing standards for health education. Previous and current efforts focused on standards have been in health-related areas where the professional does things to and for people and where the assessment of competency is immediate, quantifiable and/or measureable, e.g., in diagnostic radiologic therapy, occupational therapy, respiratory therapy,

medical records administration, environmental health, and for the primary care assistant. It should be noted that the gatekeeper for these areas of practice is the medical profession, thus the tasks to be performed are delineated, not by what the professionals are capable of doing, but by an external constraint which specifies only what each will be allowed to do in his or her respective professional role.

In contrast, education is a long and often slow process; the results are not immediate; the cognitive, affective and action domains are involved; powerful external forces in the social environment over which educators have little or no control affect the educational process, and rather than doing things to and for people, they are being helped to do things for themselves, often through development of abstract skills. The role of the educator in whatever setting should be to stand out of the way of the learning process, if learning is to be internalized and lasting.

Thus, the differences in professional standards highlighted here makes the task even more challenging. But we will never know what can be done, until we try.

In order to function in the assigned workshop role of Overviewer, and not as a participant in the group discussions, I had to deal with some of my own beliefs and perspectives. This I did (at least for this assignment) by establishing a "Mental Clearance Sale...Moving to New Conclusions...Positively Everything Must Go."

But first I want to share with you some of these personal perceptions:

1. The workshop was focused on Community, Patient and School Health Educators.

   If you examine the locus of each of these three elements, you will note that:

   "Community" is an abstraction
   "Patient" refers to a being
   "School" is an identifiable place

   I finally resolved this by assuming this was a people-centered workshop.

2. The intent of the workshop design appeared to be a view of "Community" as the territory of a designated kind of health educator, whereas my concept of "community" would include the school or university as a "community"; the workplace as a "community"; the home as a "community"; the neighborhood, the state, the nation, the world, the universe as "communities", as well as, the "community of solution." All of these settings would meet the criteria of community. Community as health has no boundaries. Perhaps we are talking about "community based health education." In that case, the parameters of the setting in which a health education program takes place delimits the community (e.g., hospital based, school based, home based).

We cannot let territorial imperatives implied in titles interfere with our common goal of education for health.

3. The "patient", as in patient education, brought to mind how we label individuals as they move from one community setting to another. Individuals are labeled as students, clients, patients, family members, the public, or employees as dictated by the respective setting. Presumably, they are to assume a certain kind of role and meet certain expectancies assigned to each role. Yet, in any <u>one</u> day, an individual could assume most or all of these roles.

   Thus, I concluded that perhaps by identifying our commonalities and differences at this workshop, there would emerge awareness that health education should be reinforcing as individuals move from one setting to another and interact with others in their environments, who also may have been health educated in other settings.

4. I had to assume that the intent of the workshop Planning Committee was to view "school" as a generic term to include all settings, such as those for early childhood populations, the kindergarten through twelve age group, college/universities, on and off campus, and adult/lifelong learning education. (At least forty percent of the workshop participants were identified as being from colleges/universities.)

   If "school" was viewed as primarily the K-12 educational experience, this, I concluded, was because the public schools require teachers to possess a credential--a license to teach. Such a requirement does not pertain, for example, to colleges/universities, nor to any other setting.

To comment on the groups as they discussed commonalities and differences, the following are some of my observations:

1. There appeared to be some contraditions, ambiguities, and paradoxes, but often these came down to semantics, unfamiliarity with trends and developments, the way in which individual conferees think (i.e., some in very specific terms, others in a conceptual way), or an understanding of the purpose of existing and emerging social structures and expanding professional roles.

   Generally, the discussions were spirited, with a willingness to listen, share, and learn. Constraints of time often prohibited in-depth discussion and clarification of complex issues.

2. The kind of institution in which an individual received his or her professional education (i.e., School of Public Health or within a comprehensive university) was reflected in some of the perspectives on an issue. For example, schools/colleges/universities are the social inventions whose reason for existence is education. Thus, an educator employed in these settings is there primarily to educate in the context of a teaching/learning process, whether it be in the areas of social sciences, physical sciences, or education about and toward health. The population is assumed to be generally in "good health" or they would not be there. Even the mainstreaming of the handicapped into public schools is viewed as providing the

opportunity for these individuals to realize their intellectual potential. If health services are provided in the school setting, the justification has been to enable students to profit from the educational experience. The same justification would hold for the work setting. Health services for employees are offered to insure that the employee is able to function in a productive way. For clarification, health services and health education in the foregoing examples are not used as synonymous terms.

In contrast, health education audiences in other community based structures become candidates for education, specifically because of a health concern or problem. These health educators function in a medical or problem oriented model which is a reflection of the way in which the other professionals in that setting have been trained (i.e., physicians, nurses, therapists, social workers). And usually, the problem is very specific and categorical--a result of the funding sources for the program.

This is not to say that health educators outside of educational institutions are not capable of planning and carrying out educational programs focused on wellness and total health. It is simply a reality that the orientation of the social structure and setting determines the boundaries of the health educator's role and functions.

3. A group discussion on content (knowledge) and process appeared to be caught up in a dichotomy of these two educational facets. Had time permitted an extended discussion, agreement might have been reached that content and process are interrelated. Content serves as the vehicle for process/methodology. If an educator wants to develop skills in critical thinking, one must have something to think critically about. Conversely, if a goal is to provide specific health information, a method/process is used to convey such.

   For example, in the nominal group process used in this workshop, the steps involved could not have been executed in a vacuum. We had to have content in the nature of problems, questions and issues to carry out the process.

4. In another group, discussion about public relations arose--the question being as to whether this was a competency common to all health educators. The question can only be answered by saying that we do not decide whether or not we will have public relations. Planned or not, it will go on as long as we are in full purview of the various publics we serve, and public funds support our efforts. I trust that this group concluded that we all should develop our competencies and learn how to educate our publics if our educational programs are to survive and thrive.

5. "Practice" was used freely in the discussions by the "public health" professionals. The term is derived from the medical model, that is--physicans practice medicine (which has never been reassuring to me).

   In educational settings, the term has been used only to apply to "practice teaching" before the prospective teacher is certified to

teach. (Parents would take a dim view of teachers "practicing" on their offspring--while being paid to teach.) Today, the term "student teaching" is used more frequently for this preservice experience.

6. In another instance the question was raised as to whether teachers in schools educate other teachers. Not only should they be prepared to educate each other, but also to educate school administrators, school board members, parents and other decision-makers. The continuous process of curriculum development, location and evaluation of resources, sharing and exchanging of ideas--these are on-going in the educational setting. Currently, a leading negotiable item in collective bargaining is an increasing demand by teachers for developing their own inservice education programs.

   Thus, it seemed apparent that one function, that of educating other professionals, is a commonality to all health educators. In every social structure--agency, hospital, school/college/university or whenever a health educator functions, there must be on-going education of other professionals, administrators, boards, advisory groups and others, if health education programs for constituency groups are to succeed.

7. In defining function, the discussion seemed to focus on only those functions performed for the agency/institution that pays one's salary. A suggestion was made that legislative skills be left to professional organizations, but these organizations are made up of people--us. So it seems that function must be interpreted to include a wide range of environments extending beyond our employing agency.

   As an example, the National Education Association, the largest professional organization in the world, has become politically active by providing workshops and seminars, so that classroom teachers can perform effectively in the political arena.

8. In discussing the goals of health and health education, it seemed that we have little choice as to whether, as professionals, we should agree because whatever the population group and whatever the setting, the same referents for the meaning of health and health education should be accepted. Educational linkages must be developed so that there is coordinated effort that extends to other community settings where disruptive or supporting forces exist and interpersonal relationships occur. As individuals move among various settings, often within a day, education about and for health must have a common reference basis if there is to be continuity and reinforcement. None of us needs to be reminded of the incredible sums of money that are spent for information and messages that come from other sources, powerful and often conflicting, which are outside of our areas of influence, but which compete with educational goals.

9. As I listened to the generation of ideas about professional goals, functions, and competencies, I tested many of these in every discussion group against a framework of broad key concepts to determine what could be subsumed under each. These were:

... Communication
... Knowledge and Resources
... Process and Methodology
... Learning and Behavioral Theory
... Coordination and Supervision
... Organization and Administration
... Planning and Policy Formulation
... Research and Evaluation

It is characteristic of any professional group to think about skills and competencies in terms of the highest level of attainment. Yet, a health aide who has been enlisted to assist in a community-based health education program must have certain communication skills whether these be on a one-to-one basis or in a neighborhood group setting, and they may be required to communicate with use of visual materials, via telephone, in a video tape message or to be interviewed by the press. If the program has a research and evaluation component, health aides who may assist in maintaining records or collecting data should have an understanding of the important contribution they can make to the outcome of the research or evaluation effort.

Should the health educator who plans to teach in a K-12 school setting need to be professionally prepared in the principles of epidemiology? Since the elementary school age child experiences communicable diseases, children in this age group can deal intelligently with simple epidemiological principles. As learning progresses through the various grade levels, students can deal with increasingly complex dimensions of the epidemiological model.

Thus, a commentary on this aspect of the group discussions would be:

Different kinds of health education responsibilities require personnel with different levels of professional preparation and experience. The significant phrase here is different levels, but not significantly different preparation.

10. If differences do exist among the population groups we serve, there is reason to predict that the future will find all social structures increasingly crossing territorial and age boundary lines. Parents will continue to come to schools for educational experiences. The school age group is participating in other community based programs. Hospitals are extending their educational efforts to follow discharged patients into extended care settings, the home, and workplace. Public service and commercial television, as well as printed media, are reaching the public with programs that involve the viewer and reader to react and respond. It is obvious that health educators of the future will need to be flexible and adaptable, if they are to use their unique skills along with other professionals whose roles and responsibilities are expanding and changing.

Thus, Role, Function and Setting are interrelatd and interdependent. As any one of these change, so will the other two.

We started out by saying, "Let's Get Our Act Together." We need to recognize also that others are getting into the act. Perhaps, health educators have been marching to the beat of a different drummer and now medical personnel, health planners, economists, psychologists, sociologists, therapists, and policy decision makers have discovered the beat.

Fifteen years ago, health educators were commenting publicly on the escalating costs of medical care, the excesses in construction of expensive hospitals, the expenditures for costly technology, and the preoccupation with the sick. Yet only within the past four or five years, have policy makers discovered these same conditions. Why wasn't somebody listening?

We must stay attuned to cultural, economic, legal, political, social and technological forces and to the myriad of social movements--for these will affect the human condition--and in turn our professional roles.

Activists movements related to human rights, ecological issues, the changing role of women, protection of the abused and the battered, rights of consumers, demands for cultural identity, futurism, bioethics, transitions in values and family patterns, global issues, government interventions, planetary space station--these cannot be ignored as if they had no meaning for what we are discussing at this workshop. It may seem paradoxical to say that, while striving for standards for our specialized professional field, we must also be generalists--interested in making connections, identifying relationships, recognizing the interdependence of all forces and trends--in essence, not just learning "more and more about less and less."

The rhetoric about the importance of health education has never been more prolific and, although the allocation of support has not kept pace with the pronouncements, let us be optimistic about the future.

I appreciate the opportunity provided me to serve as one of the two Overviewers for this stimulating workshop.

CHAPTER VI

WORKSHOP RECOMMENDATIONS

WORKSHOP RECOMMENDATIONS

The participants presented recommendations for the future direction of health education in relation to preparation and practice of the total field, regardless of practice setting or speciality focus. These recommendations represent consensus on the part of the group and were viewed as positive action oriented steps to achieving a unified and acceptable approach for examining the preparation and practice of professional health educators.

RECOMMENDATIONS

- That each member organization of the Coalition assume responsibility for disseminating the proceedings of this Workshop. And that each group identify the implications of this Workshop for its own membership and explore the resources that it can commit to achieving the necessary follow-up to the Workshop.

- That the Planning Committee for this Workshop become a National Task Force on the Preparation and Practice of Health Educators. And that members of the Planning Committee continue to serve on the Task Force, subject to approval by the Organizations they represent.

- That the Task Force, including a representative from the Office of Education, be charged with the responsibility for developing a plan of action leading to a credentialing program within a specific time frame for the total field of health education. Specifically, the Task Force will:

  - serve as a liaison with health education organizations, and with pertinent government offices, including the Bureau of Health Manpower, and the Bureau of Health Education

  - establish priorities

  - seek funding to support a credentialing effort.

- That the plan of action developed by the Task Force lead to:

  - a survey of field practice including a synthesis of existing research

  - a concrete statement of the State-of-the-Art of health education

  - an assessment of health educator competencies

  - development of performance criteria

  - delineation of performance criteria

  - delineation of core curriculum requirements for both entry level and specialized health educators.

- That government programs and private agencies with health education components require staffing by qualified health educators.

CHAPTER VII

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APPENDIX A

COMMONALITIES AND DIFFERENCES REPORT

HEALTH EDUCATION

The commonalities and differences that attend the professional preparation of health educators evolve around a sequence of five directional questions and one boundary question. The way in which health educators "answer" or "presuppose answers" to these questions and where these answers or presuppositions take them are the primary determinants of what "goes into" the professional preparation of contemporary health educators.

If you wish to reveal the commonalities and differences among health educators (patient, school, community), administer the following questionnaire to a large sample of health educators. The results should be meaningful in your attempts at professionalization.

THE CENTRAL DIRECTIONAL QUESTION:
WHY DO HUMANKIND PARTICIPATE IN UNHEALTHY BEHAVIOR?

I. Dependent Question A: Is it because they don't know what constitutes healthy behavior?

Proposed Answers (check single most appropriate answer)

( ) Yes, this is a reason and I estimate that it accounts for more than 75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 50-75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 25-50% of all unhealthy behavior.

( ) Yes, but my estimate is that it accounts for less than 25% of all unhealthy behavior.

( ) No, this is not a reason for unhealthy behavior.

Question B: Based upon your answer in Part A, what percentage of the professional preparation program of a health educator do you feel should be devoted to matters of health knowledge and ways of communicating this knowledge. Mark column one for undergraduate students, column two for students at master's level, and column three for doctoral students.

( )	( )	( )	Less than 10%
( )	( )	( )	10-20%
( )	( )	( )	20-40%
( )	( )	( )	40-60%
( )	( )	( )	60-80%
( )	( )	( )	More than 80%
( )	( )	( )	This should not be a concern of the health educator

II. Dependent Question A: Is it because they have learned in Sense I but not Sense II what constitutes healthy behavior?

Sense I = Knowledge of facts or what has been offered as fact; learner accepts no responsibility for truth or fallacy; what's learned may be meaningless or inconsistent; rote learning.

Sense II = Learning that is pervaded by enough interest on the part of the learner to cause him to attempt to verify "proposed knowledge"; Sense II learning must square with what the learner already knows or thinks he knows; it must be meaningful, understood, consistent; Sense II learning equals wisdom vis-a-vis facts.

Proposed Answers (check single most appropriate answer)

( ) Yes, this is a reason and I estimate that it accounts for 75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 50-75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 25-50% of all unhealthy behavior.

( ) Yes, but my estimate is that it accounts for less than 25% of all unhealthy behavior.

( ) No, this is not a reason for unhealthy behavior.

Question B: Based upon your answer in Part A, what percentage of the professional preparation program of a health educator do you feel should be devoted to health-knowledge-Sense II and communicating in Sense II? Mark column one for undergraduate students, column two for students at master's level, and column three for doctoral students.

( )	( )	( )	Less than 10%
( )	( )	( )	10-20%
( )	( )	( )	20-40%
( )	( )	( )	40-60%
( )	( )	( )	60-80%
( )	( )	( )	More than 80%
( )	( )	( )	This should not be a concern of the health educator

III. Dependent Question A: Is it that "knowing what constitutes healthy behavior" people don't value health? That they have nothing to be healthy for? That something has "sapped" their will to be healthy? To live?

Proposed Answers (check single most appropriate answer)

( ) Yes, this is a problem in unhealthy behavior and I estimate that it accounts for more than 75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 50-75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 25-50% of all unhealthy behavior.

( ) Yes, but my estimate is that it accounts for less than 25% of all unhealthy behavior.

( ) No, this is not a reason for unhealthy behavior.

Question B: Based upon your answer in Part A, what percentage of the professional preparation program of a health educator do you feel should be devoted to matters of "coming to value health," "finding something to be healthy for" and "how to deal with these problems." Mark column one for undergraduate students, column two for students at master's level, and column three for doctoral students.

( )	( )	( )	Less than 10%
( )	( )	( )	10-20%
( )	( )	( )	20-40%
( )	( )	( )	40-60%
( )	( )	( )	60-80%
( )	( )	( )	More than 80%
( )	( )	( )	This should not be a concern of the health educator

IV. Dependent Question A: Is it that knowing what constitutes healthy behavior and valuing health people are unable to direct their own life decisions because of certain overriding social or psychological dynamics.

Proposed Answers (check single most appropriate answer)

( ) Yes, these social and psychological dynamics are responsible for unhealthy behavior and I estimate that they account for more than 75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 50-75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 25-50% of all unhealthy behavior.

( ) Yes, but my estimate is that it accounts for less than 25% of all unhealthy behavior.

( ) No, this is not a reason for unhealthy behavior.

Question B: Based upon your answer in Part A, what percentage of the professional preparation program of a health educator do you feel should be devoted to study of the social and psychological dynamics of health behavior and the application of this knowledge. Mark column one for undergraduate students, column two for students at master's level, and column three for doctoral students.

( )	( )	( )	Less than 10%
( )	( )	( )	10-20%
( )	( )	( )	20-40%
( )	( )	( )	40-60%
( )	( )	( )	60-80%
( )	( )	( )	More than 80%
( )	( )	( )	This should not be a concern of the health educator

V. Dependent Question A: Is it that people can't afford healthy behavior?

Proposed Answers (check single most appropriate answer)

( ) Yes, this is a reason and I estimate that it accounts for more than 75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 50-75% of all unhealthy behavior.

( ) Yes, and my estimate is that it accounts for 25-50% of all unhealthy behavior.

( ) Yes, but my estimate is that it accounts for less than 25% of all unhealthy behavior.

( ) No, this is not a reason for unhealthy behavior.

Question B: Based upon your answer in Part A, what percentage of the professional preparation program of a health educator do you feel should be devoted to ways of dealing with this problem. Mark column one for undergraduate students, column two for students at master's level, and column three for doctoral students.

( )	( )	( )	Less than 10%
( )	( )	( )	10-20%
( )	( )	( )	20-40%
( )	( )	( )	40-60%
( )	( )	( )	60-80%
( )	( )	( )	More than 80%
( )	( )	( )	This should not be a concern of the health educator

The term "health" is used in at least two different senses:

Sense I
Health

- biological integrity
- having attained the full biological potential for physical and intellectual growth and development and for relating harmoniously and productively with others
- health is potential for human activity
- it is a means to something
- it is not an end in itself
- sometimes labeled "the medical definition of health"

Sense II
Health

- biological integrity (Sense I Health) is appropriate to animals in the wild but not to humans
- for human kind, health is a measure of an individuals ability to function within his own value system
- health is very relative
- it includes not only biological integrity but also "the use of biological integrity in pursuing alternative values"
- health, thus, includes such factors as aesthetic experience, truth, integrity, authenticity, friendship, and religion

I. Regarding the two senses of health, which of the following best describes your view of the boundaries of health education:

( ) 1. In recent years health education has emphasized study of the behavioral sciences. This emphasis, however, has been motivated by a desire to better understand the predisposing, enabling, and reinforcing factors contributing to biological integrity. The "bottom line" has always been to help people attain their full biological potential for physical and intellectual growth and development, and for relating harmoniously and productively with others. Health education should limit itself to Sense I Health.

What a person "does or does not do" with their biological integrity is important but it should be outside the boundaries of health education. This position recognizes that "how the individual utilizes biological integrity" is a part of health. However, it does not legitimize "instruction in the use of biological integrity." The latter falls in the purview of religion, philosophy and political science, to mention a few.

( ) 2. Preventive medicine and biological integrity are outdated as components of health education and should be put "out of bounds." Biological integrity is the purview of medicine, nursing and the "non-education" aspects of public health. We already have a disproportionate number of professions dealing with disease and premature death. What the future requires is a "health education" designed to improve the quality of life and to increase the possibility of personal fulfillment. Disease and premature death are minor problems as compared to "purposelessness." Biological integrity is nothing unless people have a purpose "to expend it on." Sense II Health is the basis of high-level wellness. It is the future.

( ) 3. The positions advanced in answers one and two are unreasonable. Health education must deal with both "biological integrity" and "the use of biological integrity." The notion of holistic health cannot be ignored. This position realizes that it is impossible to establish boundaries for a profession that attempts to promote biological integrity and one that also concerns itself with "the ends" toward which this potential should be expended. But that's the nature of health. History reveals that the nature of health is an open question: one that can never be answered except on a personal level. Likewise, the nature of health education is also an open question. Not only is this the case, but further, it represents a healthy situation. All professions don't have to fit into "clean categories." So we have no boundaries! Neither do parents, nor lovers, nor friends, nor philosophers, nor spiritual leaders, nor politicians. Maybe the really important <u>things</u> don't have boundaries. Maybe the professions of the future will be holistic in nature.

Editor's Note: The participants were asked to answer only the last question. The results were as follows:

Response	Respondents	% of Total
Answer 1	10	30%
Answer 2	7	21%
Answer 3	12	36%
No Response	4	12%
Total	33	99%*

*Percentage does not total 100% due to rounding error.